THE USE OF PRISON CONFINEMENT FOR THE TREATMENT OF MULTIPLE DRUNKEN DRIVER OFFENDERS: AN EVALUATION OF THE LONGWOOD TREATMENT CENTER

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ABSTRACT

In March of 1985, the Massachusetts Department of Correction (DOC) embarked on a unique mission with the opening of the Longwood Treatment Center, the state's first minimum security prison designed exclusively to detain and provide alcoholism education and treatment to multiple drunken driving offenders. At Longwood, the DOC contracts out the treatment services to Valle Associates, a private treatment vendor, and retains responsibility for the management and security of the facility.

Coterminous with the opening of Longwood, a process evaluation was begun. Its purpose was multifaceted - to determine the extent to which the program was implemented as planned and serving the target population as specified, to address preliminary outcome measures of program success, to analyze the various costs of the Longwood program, and to provide feedback to program administrators concerning program implementation and operation.

The following report presents the results of the evaluation effort. First, research revealed that the program was indeed implemented as planned. Although a series of internal and external forces impacted the process of implementation and subsequently led to program adjustments, the overall intended program structure and context was achieved and Longwood emerged as a smoothly run, professional operation.

Research also determined that the program serves the intended target population. Offenders served at Longwood are neither new to the courts nor to public and private alcohol treatment programs.

Secondly, preliminary outcome measures revealed that relatively few individuals completing the program are rearrested and returned to prison within one year of release. Our research demonstrated that 6% of the Longwood program completers were returned to prison within one year of release. This compares to a department wide recidivism rate of 25% and to a rate of 19% for other low security institutions similar to the Longwood program.

Although in general the research findings were positive, a number of issues were raised and recommendations made to program administrators concerning program modifications. For example, the aftercare component of the program needs to be strengthened, the counseling and correction staffs need to be restructured, and the costs of operating the Longwood program need to be reevaluated. A discussion of these and other issues is included in the report.

In conclusion, the innovative concept of providing alcohol education and treatment to a specific, designated and relatively homogeneous population within the confines of a correctional setting, was proven through this evaluation to be not only feasible, but desirable and practicable. Although the study was not intended as a formal outcome evaluation, preliminary findings suggest in fact that the program is effective in reducing recidivism among multiple drunk drivers, as well as impacting on the alcoholic behaviors of such offenders. It is recommended that a future formal outcome evaluation be initiated.

FOREWORD

The following study was accomplished through the work of a number of individuals functioning as a research team. The team approach and the team composition is unique when compared to studies traditionally done by the Research Division. In addition to employees of the Research Division, team membership consisted of student interns from area universities, Cooperative Education placements from the Northeastern University program, and a staff member from the institution under study. Though individual roles and tasks frequently overlapped and merged, it is important to recognize and acknowledge individual efforts. Dr. Daniel LeClair, Director of the Research Division, served as the principal investigator for the study. In that capacity he wrote the original research design and supervised the subsequent research processes.

Richard Drorbaugh joined the research team during the formative stages of the design construction. He was recruited to serve as a summer intern under the auspices of the Public Policy Program of the Massachusetts Internship Office. Richard's task was to fulfill the early field work assignments by attending program meetings, sitting in on treatment activities, and generally observing the implementation and early stages of program operation. This work helped in providing the background material from which the evaluation design was developed.

Dallas Miller, a research assistant with the Research Division, was assigned to collect data with respect to the client selection procedures in order to determine whether or not program participants were drawn from the targeted populations. Much of the material collected by Dallas informed the discussions in Section V of this report.

Edward Klotzbier was recruited from the Northeastern University Cooperative Education Program to serve as one of the senior research analysts for the study. Edward was responsible for administering interview schedules to the program staff and to the program clients. He also developed and organized study files, attended program sessions, and was involved in general program observation. Materials collected from Edward were utilized throughout the various research processes.

Lynn Felici served as the second senior research analyst. Lynn was initially recruited as a student intern from the University of Massachusetts-Boston and she was assigned to investigate and document the history of the Longwood program. To accomplish this task, she interviewed many of the key initiators of the program and traced and compiled all available documentation and memoranda relative to the facility's origins. Upon her graduation from U-Mass, Lynn joined the research team as a senior research analyst. She assisted in administering interview schedules to program staff and also assisted in the program participation and observation research tasks. After the completion of these tasks, Lynn was responsible for incorporating all of the written summaries of the individual researchers into one comprehensive report. Thus, in this role, Lynn wrote the first draft of the final report.

David Dowling, a second student placement from Northeastern University Cooperative Education Program, was primarily responsible for gathering information to be used in the cost analysis of the Longwood program.

Scott Rand, the aftercare coordinator at Longwood, assisted the researchers by providing a description of the aftercare component at Longwood, and by furnishing statistics on the post-Longwood behavior of program completers. The above information was used in the section of the study examining outcome measures of program effectiveness.

Dr. Michael W. Forcier, Deputy Director of Research, served as the study editor. He reviewed initial drafts and made substantial contributions to the sections on issues and recommendations as well as to other sections of the report. As a new member of the Research Division, his fresh approach and knowledge of alcohol treatment issues greatly aided the editing process.

The research team would like to acknowledge the significant support received from Michael V. Fair, the Commissioner of Correction, and his Senior Executive Staff, especially Dr. Dennis Humphrey, in the process of conducting this study. Our requests for staff, resources, and access to records were more than optimally met. The priority given to the research assured cooperation throughout the Department and greatly facilitated our task.

We would like to acknowledge the support and cooperation that was rendered by David MacDonald, the Superintendent of the Longwood Treatment Center. He gave us office space at the facility in the midst of program activities. This allowed an invaluable direct exposure to what we were studying. He also gave free access to all records, staff, and program activities on an around the clock basis. His entire staff at the facility extended the same level of cooperation. In addition, the Valle Associates staff are thanked for giving freely of their time and allowing members of the research team to observe various treatment components.

Finally, we are greatly indebted to Suzanne Edwards for the word processing of the multiple drafts and final copy of this report.

Thus, our finished product must be viewed as the result of the hard work of a large number of individuals and was made possible by a wide base of administrative support. Any shortcomings of the research are the responsibility of the principal investigator.

I. INTRODUCTION

A. Overview of the Program

1. Drinking Driver to Drunken Driver:

> Consider two different images of the drinking driver. One may imagine the ordinary social drinker who happens to overindulge, and who, missing a stop sign, is detained by the police, thereby getting into trouble. Or imagine the drunken driver, one who is habitually drunk, a reeling, stumbling, insensate hazard to everyone on the road, including himself. The image that one constructs of the driver who drinks has much to do with the recommendations for action that one might embrace as a means of curtailing drinking drivers.
>
> Ernest R. House
> Evaluating With Validity

Beginning in the late 1970's American society witnessed an accelerated public concern with the problems associated with drinking and driving. Indeed, for public health and criminal justice agencies the problem has emerged as one of the most salient issues of the day. The public concern and the subsequent pressure on social agencies for action evolved out of a series of events through which mutually interacting factors influenced an escalation process from which a major social issue emerged. First, the general public gradually became more aware of the frequency and severity of victimization caused by the drinking driver - serious traffic fatalities, homicides, particularly of young children, hit and run accidents and property destruction. Second, advocacy groups such as Mothers Against Drunk Drivers (MADD) began to form, and as they became politically sophisticated and articulate, their forces further escalated public awareness and concern. Third, increasing media coverage of the event further educated the public to the issue and

further mirrored the resultant public concern. Finally, legislative and executive branches of government began to be influenced by the concern and in turn felt compelled to react. Thus, the escalation process was completed, and a major social issue had emerged.

During the same time period in which the problem of drinking and driving was emerging as a major social issue, the public image of the drinking driver was undergoing a profound transformation. Previously, the dominant public image was that of the ordinary social-drinking citizen who happened to get caught. Perhaps in some instances poor judgement rather than bad luck was the believed culprit; perhaps in other instances an emerging serious drinking problem was acknowledged. However, the event was rarely viewed as a serious criminal offense, and the individual involved was rarely viewed as significantly different from the general population. Therefore, the public supported the practice of treating the event by moderate legal actions such as supervised probation and fines. This was a practice similar to typical remediations currently practiced for other motor vehicle related offenses such as illegal parking, speeding or running a red light.

Today however, the dominant public image of the drinking driver has significantly changed. It has been transformed into that of a perceived habitual and pathological drunk -- a chronic alcoholic who is believed to be a potential danger to the general public and to self. Images of vehicular homicide, hit and run accidents, innocent victims, and multiple episodes more frequently come to mind. No longer is the drinking driver viewed as an ordinary citizen -- a social drinker. Instead, the image of a drunken driver points to a small subset of the population characterized by a special problem -- chronic alcoholism. Recommendations for remediation have changed along with the change in the public image. There is more apt to be pressure for medical treatment in a public health setting and more recently an expectation for punishment through confinement in a prison setting.

Thus, the civil delinquent -- the drinking driver -- has been transformed into a patient/criminal -- the drunken driver.

With the image transformation completed, it was inevitable that current law enforcement, detection practices, and current penalties meted out for individuals found guilty of drunken driving would be judged lenient. Therefore, it would be expected that pressures for increased detection, increased certainty of punishment, and increased penalties would occur.

2. The Massachusetts Response:

In September of 1982, the Massachusetts Legislature passed an "Act to Increase the Penalties for Operating a Motor Vehicle While Under the Influence of Intoxicating Liquor". Though the law provided for alcohol education, counseling programs, and residential treatment programs in public health settings, it was most saliently characterized by the provisions for increased certainty of punishment for repeat offenders by mandatory incarcerations in county correctional facilities.

The strict enforcement of the Massachusetts law resulted in a dramatic increase in Operating Under the Influence (OUI) commitments to county correctional facilities, so much so that approximately 25% of all county commitments are OUI offenders (Miller, 1985). This increase led to significant changes in the demographic characteristics of the county institutions, which had serious budgeting, programming, and planning implications for these facilities.

First and foremost, the increase in commitments for driving under the influence greatly worsened an already severely overcrowded county correctional system. For example, from 1981, a year prior to the new law, to 1983, a year after the law, the number of total county commitments rose from 6246 to 9617, an

increase of over 50% (Miller, 1985). In addition to contributing to the further overcrowding of prisons, these new commitments represented a new type of county inmate, thus bringing forward programmatic implications. That is, commitments for driving under the influence shared a set of demographic characteristics in contrast to the heretofore typical county inmate. Research by Williams (1984) pointed out that offenders committed for driving under the influence were older, more educated, more likely to be married, and received shorter sentences compared to the remainder of the county commitments. Further research by Moore (1985) revealed that county correctional officials reported that the OUI offender was generally a chronic alcohol abuser with a non-criminal background. Where long criminal records did occur, they were for alcohol-related offenses.

These important changes in demographic characteristics brought serious planning and programmatic implications to the county correctional system. Yet program development was almost totally constrained by the overcrowded conditions, the serious lack of financial resources, and the particular nature of the relatively short OUI sentence. In fact, research by Moore (1985) pointed out that most counties offered limited programming for the OUI offender. Under these circumstances, it became evident that the county system of incarcerating OUI offenders typically served only the custodial and thus punitive function, while in many cases the treatment or rehabilitative function was not being met.

To deal with this situation, the Sentencing and Corrections Committee of the Governor's Statewide Anti-Crime Council reviewed ways to accommodate the law without incurring a consequent crippling of the county correctional system and without precluding the possibility of treatment and rehabilitation. In May of 1983, the committee issued their Preliminary Report on Prison Overcrowding: Steps Towards A Solution, and in this report, recommended the establishment of three one hundred-bed statewide facilities to house offenders sentenced under the "drunk

driving" legislation. The committee specifically stated that these facilities would be designed to serve two primary functions: first, to help relieve overcrowding in the county houses of correction; and second, to provide offenders of the law with appropriate counseling and treatment services. All residents of the facilities would be transfers from the county houses of correction where they had begun serving their sentences. The specific treatment program was to include individual and group counseling, closely supervised outdoor recreation, and participation in in-house and community-based work-release programs.

The Longwood Treatment Center located in Boston was the first of the proposed centers to open. At the outset, a stated objective was to develop in conjunction with the Department of Correction's Research Division a process evaluation model to examine the implementation process, to describe the operationalized program, and to set the foundation for determing the effectiveness of alcohol treatment and education at the Longwood Treatment Center. This report presents the results of the evaluation effort.

B. Purpose of the Program Evaluation

The present evaluation of the Longwood Treatment Center represents a formal examination of the program itself--its conception, the population it serves, its current functioning, its financial costs, and its societal impact. The formal method to be used for this examination is the Program Evaluation Model. In general, the ultimate purpose of a program evaluation is to provide feedback within a social system. Once a program such as the Longwood Treatment Center has been developed and begun, it takes on a life of its own. It is only through formal and informal feedback that we are able to assess what this new life is. In general, program evaluations provide formal feedback through a multiplicity of tasks. Such

tasks include techniques for a determination of whether a proposed human intervention strategy is implemented and conducted as planned, whether it reaches the target population as specified, and whether the service actually achieves its intended goal as stated. In the accomplishment of these tasks, the evaluators are providing feedback material to a variety of interested parties -- program managers, program planners, program funding sources, legislators, and the general interested public. In turn, the interested parties can use the feedback material for a variety of purposes. Feedback material may be used to improve program effectiveness, to assist program managers in making future program level decisions, and to provide program accountability to the public and to funding sources. Additionally, feedback material may be used to determine whether the program should be continued, expanded, and/or replicated in other settings.

The evaluation effort undertaken for the Longwood Treatment Center consists of three components. First, the evaluation consists of a process/implementation design which serves to document the extent to which the program is being implemented as planned, is providing services consistent with program goals and objectives, and is serving the specified target population. Secondly, the evaluation focuses on an assessment of the outcomes achieved by the program and will serve to document the extent to which behavioral changes of program participants may have been achieved. In this phase of the evaluation, a determination will be made on the feasibility of conducting a formal outcome evaluation, or if such is not possible, whether informal tentative feedback might be substituted. Finally, the evaluation consists of a cost analysis of the program. It serves to provide a determination as to whether the program is able to achieve its services at a reasonable cost and whether dollar values can be assigned to outcomes achieved.

II. RESEARCH METHODOLOGY

A. Research Questions

Specific research questions were developed to give structure and direction to the evaluation process as well as to ensure that the essential components of the program were adequately covered. The research questions served to define boundaries for the data collection efforts, thus avoiding the dilemma of amassing more data than could be coherently analyzed. These research questions are presented below in outline form:

1. **Is the Program Being Implemented as Planned?**
   - What goes on in the program, what does it do?
   - Were the various practices and intervention efforts undertaken the same as those specified in the program design or derived from principles explained in that design?
   - Does the staff work load match that which was planned?

2. **Has the Program Been Directed at the Appropriate and Specified Target Population?**
   - Who is the program serving and are the clients representative of the target population?
   - What are the number and types of clients utilizing project services and is the program attracting a sufficient number of appropriate clients?
   - What are the recruitment and selection methods that bring individuals into the program?
   - What are the screening methods employed in processing clients for services?
   - How do clients move through the program once they are selected as participants?

3. **Is the Program Effective in Achieving its Intended Goals and Objectives?**

   - What happens to clients after leaving the program? Are there behavioral changes?
   - How many recidivate?
   - How many continue to drink?
   - How many are employed?
   - How many continue to receive alcohol treatment?

4. **Is the Program Able to Achieve its Goals and Objectives at a Reasonable Cost?**

   - How much does the program cost?
   - How do costs vary among programmatic subsections?
   - What are the costs of delivering services for specific benefits to program participants?
   - Does the program achieve a better level of success than other programs costing the same or less to administer?
   - Is the program an efficient use of resources compared with alternative uses of the resources?

B. Sources of Data and Methods of Data Collection

The formulated research questions were used to define basic data needs and help identify the sources for those data needs. In generating data, the program evaluation employed both quantitative and qualitative methods of data collection. However, because of the exploratory nature of the research, qualitative methods predominated. For example, the collection of client demographics and prior criminal history records yielded quantitative data whereas qualitative data was secured through observations and formal interviews. The principal categories of data collection included observation, description, interviewing, examination of

program records, examination of demographic and criminal history records, and generation of outcome records. Presented below is an outline of the overall data needs and an indication of the methods of data generation.

1. **Detailed Description of Program Development**

   - Chronology of how the program evolved.
   - Identification of key initiators of the program concepts.
   - Specification of underlying theories and assumptions of program planners.
   - Specification of political and practical compromises required to launch and maintain the program.

2. **Documentation of Program Structures, Operations, Services, and the Flow of Clients**

   - Examination of records kept over the course of the program (records relating to program enrollment, attendance, intake processes, treatment plans, program placements, and release processes).
   - Examination of proposals, budgets, contracts, and annual reports.
   - Construction of an official description of what the program looks like in operation.

3. **Observations of the Program in Operation**

   a. **Direct Observation by Evaluators**

   - Multiple observations of program services.
   - Observing staff meetings.
   - Attending case conferences, intake interview meetings, and exit interview meetings.
   - Participating in group therapy sessions.
   - Accompanying specific staff members on their daily rounds.

b. Unstructured Observation by Evaluators

- Participation in informal interactions and unplanned activities.
- "Hanging out" at program facility and in surrounding community.
- Locating research office on site within program facility.
- Utilization of facility services such as cafeteria, coffee-wagon, etc.

4. **Staff and Client Perceptions of Program**

- Formal interviews with program staff (administration, treatment, custody, and consultants).
- Formal interviews with client participants.
- Formal interviews with relevant Department of Correction administrative personnel.
- Interviews with other significant parties as identified in the course of the process evaluation.

5. **Background Information on Client Participants, Derived from Department of Correction Computerized Data Base System**

- Social background characteristics (demographic data such as race, sex, education, employment history, family history, etc.).
- Prior criminal history records.
- Substance abuse history.
- Present offense history.
- Institutional variables.

6. **Cost Analysis**

- Program cost estimates.
- Comparative cost analysis.
- Review of records of expenditures, budgets, and contracts.

- Identification of costs with specific components of the program.

7. **Post-Program Outcomes**

   - Behavior observations.
   - Arrest records subsequent to release from program (recidivism).
   - Substance abuse, employment status, treatment received subsequent to program release.

C. Time Frame of Study

Development work on the program evaluation model initially began in March of 1985. At the outset, the Department of Correction Research Unit opened a satellite research office on site at the Longwood Treatment Center, and began the research process by scheduling two days a week at the satellite office. In June of 1985, a full time student intern was hired and worked on site throughout that summer. During this period of time and prior to the formal beginning of the evaluation, a DOC research assistant, working out of Central Office, was assigned to develop a data base while design construction and preliminary observation was underway at Longwood.

The formal research process began in January of 1986. From January 1986 through June of 1986, a second full time researcher began formal interviews of staff, residents, and other relevant parties at Longwood, while a third researcher examined the facility's records and historical documents and began the writing of the report. From July through October 1986, one researcher and a second student intern continued to maintain a full time presence on site at Longwood, observing the treatment component and other regular activities of the program, and examining the records of the clients served at the facility. In October 1986, the

research team vacated the satellite office and relocated to DOC Central Office in Boston. From October through December 1986, researchers began the preliminary examination of outcome measures of program success by obtaining post-release court records of a number of graduates. During this period, formal analysis of the accumulated research material began and writing of the report was underway. By June of 1987, the final evaluation report was written, edited and ready for publication. Thus, the entire research effort transpired over the course of 2 years, 18 months of which were spent in direct observation of program implementation.

D. Presentation of Evaluation Results

The results of the evaluation effort will be presented in Sections III through IX. In order to address the research questions delineated above, each section of the report will examine individual components of the Longwood program, beginning with the facility's origins, continuing with a description of the program in operation, and concluding with a summary of salient issues and recommendations for future program planning.

Section III examines the Longwood program by detailing its history and foundation. The intent of this section is to provide the reader with knowledge concerning the development of the Longwood program in order to later gauge whether or not the program is being implemented as planned. Section III will chronicle the program's evolution, identify the key initiators of the Longwood Treatment Center concept, highlight the treatment design, and briefly discuss the role of the contracted treatment vendor at Longwood.

Section IV of the report will elaborate the specific goals and objectives of treatment at Longwood, as well as delineate the responsibilities of the various staffs at the treatment center. Section IV details the philosophy and goals at

Longwood in order to: 1) enable the reader to understand the motives behind the present program operation; and, 2) discern whether these original goals and objectives are being met in actual daily program operation.

Further, in order to understand how the various components of the Longwood program interact to meet the stated goals and objectives, Section IV will describe the various staffs and each staffs' contribution to meeting the goals of treatment at the facility. By examining each of the staffs at Longwood, Section IV will answer the research question, does staff workload match that which was planned?

To discern whether the Longwood program has been directed at the appropriate and specified target population, Section V of the report will examine the population in detail. Section V will: a) highlight the debate over the background characteristics of drunk drivers in general; b) examine the screening process whereby county OUI inmates are transferred into the Longwood program; c) compare 1985 Longwood program participants to other state and county inmates for that same year; and, d) examine the level of alcohol impairment among Longwood participants.

Section VI of the evaluation will describe the Longwood program in detail by examining program structures, treatment services, and flow of clients from admission into the program to release. The information in Section VI refers to the daily operation of the treatment center, and was garnered from direct observations by research evaluators, unstructured observations by evaluators, and structured interviews with both program participants and staff at the treatment center.

Section VII of the Longwood evaluation will highlight outcome measures of program effectiveness in an effort to assess the program's impact on residents' post-release adjustment. Specifically, Section VII will highlight measures of program effectiveness through the subsequent arrest records of Longwood releases, including the number of releasees returned to prison within one year of release

(recidivism), and through contact between released residents and the Longwood aftercare coordinator.

Section VIII analyzes the various costs of the Longwood program, breaking down costs by subsidiaries, and compares those costs both to other alcohol treatment programs and other correctional institutions. Finally, a discussion of the most salient issues unearthed in the evaluation and recommendations for program changes and/or improvements will be presented in Section IX of the report.

III. HISTORICAL DEVELOPMENT OF THE LONGWOOD TREATMENT CENTER

In order to address the issue of whether the Longwood program was implemented as planned, the following section describes the chronology and historical development of the Longwood program. This section identifies the key initiators of the Longwood concept, examines the underlying theories and assumptions of the program planners, and highlights some of the political and practical considerations required to launch the Longwood program. Included in this section is a brief discussion of the goals of treatment at Longwood. Finally, this section concludes by introducing the alcohol treatment vendors contracted by the Department of Correction (DOC) to provide alcohol treatment to Longwood program participants.

A. The Origins of a Proposal

In May 1983, the Sentencing and Corrections Committee promulgated the establishment of three regional state-run OUI facilities to ameliorate overcrowding in the county jails and houses of correction. In its Preliminary Report on Overcrowding: Steps Towards a Solution, submitted to the Governor's Statewide Anti-Crime Council, the Committee argued that, "overcrowding has jeopardized the ability of sheriffs and corrections managers to prevent escapes, to maintain order within facilities in a manner which ensures the safety of those who live and work there, and to provide basic health and program services for those who require them". Committed to providing relief within the state and county system as quickly as possible, the Committee focused on "expansion strategies which would be affordable and which would produce space in the very short term". The

establishment of three regional correctional facilities for the confinement of persons convicted under the OUI law sought to meet that goal.

Initially, the Committee proposed to open the first of the three facilities within four to six months from the date of site selection. While the Committee asserted that further analysis would be required to determine the most appropriate sites for the facilities, DOC officials made a first informal visit to the present Longwood Treatment Center site to conduct a preliminary assessment of the available property in May 1983. The property on South Huntington Avenue in the Jamaica Plain section of Boston formerly housed the Longwood Hospital, and had been closed for about two years. DOC officials contended that, with an accomodating capacity of at least 100 individuals and "ample space for support services, counseling & administrative offices", the facility would be ideally suited for the purposes outlined in the Committee's Anti-Crime Council Report. It needed little renovation, was equipped with a sprinkler and fire alarm system, kitchen facilities, accessible to public transportation, and provided ample parking.

The building, owned by the Huntington Hospital Corporation, was on the market for $750,000. The owner of the building which houses the DOC's Park Drive Pre-Release Center expressed interest in the property. At Park Drive, the DOC leased the property on a 5 year basis, and following the preliminary review of the Longwood Hospital site, the Department entertained the prospect of repeating the arrangement at Longwood, thus being able to monitor the extent of incarceration resulting from the new law over 3 to 5 year intervals before investing large sums of money into other buildings.

According to DOC documents, it was assumed at this point (September 1983) that the target population for the potential OUI facility would mainly consist of "male minimum/pre-release security level inmates who possessed little criminal history and (were) likely to be in need of substance abuse programming".

It was assumed that they would likely be:

- admitted to the facilities from the counties (not the courts) on a percentage based on OUI statistics with the counties responsible for all transportation (court, hospital etc...);
- booked and receive health screenings at the county level prior to admission to the facility; and,
- have completed detoxification, if necessary, prior to admission.

It was also assumed at that juncture that alcohol treatment would be provided by coordinating community resources with substance abuse programming, "thus reintegrating the individual back into the community while attempting to maintain continuity in current employment and/or opportunities and family relations".

B. Community Raises Objections

The potential lessor appeared before the Boston Zoning Board for a "boarding house" variance, which would have allowed him to lease the property to the DOC to house the aforementioned county population. In spite of assurances that the potential facility would be compatible with other institutional activity in the area and garner $32,000 in taxes for the city, unanticipated community opposition to the planned center abounded, significantly impeding approval of the variance. Resistance was registered from representatives of various neighborhood organizations with property either approximate to or abutting the Longwood site.

The community groups contended that the potential use of the facility, although billed as treatment-oriented, was primarily correctional. As such, they argued, it was undesirable and posed a threat to the children, elderly, and

handicapped in the area.

After negotiating with the Boston Zoning Board for approximately one year, Executive Office of Human Services officials and the community reached a preliminary agreement. The Boston Zoning Board ultimately approved the application of the buyer, stating that: (1) the specific site is an appropriate location for use as a custodial care facility considering the nature and number of other hospital and hospital-type institutions in the area; (2) adequate parking and easy accessibility to public transportation virtually ensured that the facility would not pose a hazard to pedestrians or congest automobile traffic; and, (3) the potential lessor's successful experience with running a similar facility in harmony with the needs of that particular neighborhood was favorable evidence for supporting this particular application.

Further, a list of provisos limiting the type of inmate to be transferred into the Longwood program, and a fairly detailed treatment program description submitted per request of the Zoning Board by the Executive Office of Human Services appended the decision by the Board. The provisos and subsequent treatment plan were drafted and included as part of the approval with the intention of accommodating the concerns of the community. Failure to adhere to them would render the decision of the Board null and void, and threaten the continued existence of the facility. The provisos are as follows:

1) the Longwood Facility shall be a 125 bed correctional facility staffed by uniformed correction officers 24 hours per day. The facility will service inmates whose governing sentences fall under the State's "Drunk Driving Law" as defined under sections 23, 24, 25D, 24E, 24G, 24I, 24J, of Chapter 90 as amended or added by MGL Chapter 373;
2) Inmates shall be placed in the facility from county and state facilities upon approval by the Department of Correction classification system

based on eligibility and suitability requirements. Specifically;

a) Inmates will have a maximum of 36 months to parole eligibility to be served at the facility.

b) Inmates sentenced to weekend, holiday, and/or evening imprisonment shall not be eligible.

c) Inmates shall not be in need of detoxification.

d) Inmates shall be free of any serious or long term medical needs which require on site medical observation and/or treatment at an outside hospital.

e) Inmates who have been convicted of Operating Under the Influence but who possess prior criminal histories which involve one or more state or federal incarcerations for violent crimes against the person -- i.e., murder, kidnapping, assault, sexual assault, armed robbery -- shall not be eligible.

Included with the provisos, as mentioned, was a description of the treatment plan submitted by Human Services. It stated that:

The primary focus of the program is to provide activities for the alcoholic offender. To this end, in-house activities will be directed toward:

1) An initial assessment of the offender's alcohol problem (i.e, is a chronic substance abuser who is not yet addicted to alcohol, is an alcoholic, is a social drinker who has an adverse/allergic reaction to alcohol, etc).

2) Individual treatment plans will be developed for each offender and may include: a) alcohol education classes; b) individual and/or group counseling; c) participation in in-house and community programs; d) structured recreation programs; e) outside recreation programs which shall occur with a high degree of decorum with acceptable community standards; and, f) other appropriate rehabilitative services.

3) Where appropriate, offenders' immediate family members (ie. children etc.) may be involved in counseling sessions to aid the offender in his or her transition back to the community as a socially responsible individual.

4) Offenders who are within 18 months of parole and who have demonstrated an ability and desire to address their substance abuse problem will be encouraged to participate in both work-release and community-based programs.

C. **Securing a Treatment Vendor**

In November 1984, a Request for Proposals (RFP) was issued for alcohol treatment specialists. While the Commissioner of Correction expressed confidence that the DOC was capable of staffing the facility with its own alcohol treatment counselors, it was decided that the DOC would contract out for a group of alcoholism professionals to oversee the treatment component of the facility, with DOC staff retaining responsibility for management, classification, and security issues. The RFP called for "applicants to submit proposals to provide alcohol education, assessment, evaluation, treatment and referrals to third and multiple offenders convicted and sentenced to county houses of correction for OUI but who will serve said sentence at the Longwood OUI Facility". The applicants were provided with a detailed description of Longwood's intended purpose, a definition of the OUI offender, the list of resident eligibility and suitability requirements, the major services to be provided, and a description of the intended mission of the counseling and treatment component.

Six vendors submitted proposals, and Valle Associates of Lynn, Massachusetts was selected as the vendor. The Longwood Review Screening Committee stated that Valle Associates (Valle) offered a highly detailed breakdown of services, had a

proven track record in the alcohol treatment field, and would provide the most comprehensive and expert program of alcohol education, treatment, and assessment for the cost.

While the hiring of treatment and security staff was taking place, the appointed Superintendent of the Longwood Treatment Center convened the first meeting of an ad-hoc Community Advisory Committee, formed with the intent of addressing community concerns by meeting on a monthly basis. As the representative of the facility, he met with the neighborhood groups in an effort to further negotiate community objections. He kept them abreast of the recent hiring, staffing, and treatment developments at the Longwood Center, and fielded their questions and concerns about such issues as security. By the time the Treatment Center was operational and the first residents were admitted in March, 1985, community relations between Longwood and the neighborhood had improved. Each group had negotiated together for almost two years since the proposal to establish a treatment facility for repeat OUI offenders was first mentioned. On both sides of the debate, agreements were reached that served to both relax the community and to ensure that the state had a carefully constructed plan for treating convicted drunk drivers before the doors to Longwood were opened.

IV. THE LONGWOOD PHILOSOPHY: GOALS, OBJECTIVES, AND STAFF OF THE TREATMENT CENTER

A. The Longwood Philosophy

The following section introduces the Longwood program by examining the philosophy, goals, objectives, and staff of both the DOC and Valle Associates at Longwood. Since its inception, the Longwood Treatment Center has undergone numerous changes, attributable to both the increasing number of residents participating in the program, and the innovative nature of the program concept itself. Although Longwood is predicated upon the concept of treatment for alcoholism, it is important to keep in mind that the facility is secure, and therefore the paramount objective of the DOC at Longwood is the detention of multiple OUI offenders and the secondary goal is treatment for alcoholism. The extent to which the goal of treatment and the goal of punishment are compatible will be touched upon in subsequent sections of this report. There are, however, basic areas where the goals of both the DOC and Valle at Longwood coincide and these are outlined in this section.

B. Goals of Treatment

From the perspective of both the DOC and Valle, the treatment component of the program is based on the philosophy that "alcoholism is a complex, multi-dimensional illness that must be understood in the context of an individual's drinking history, personality, environment, and skill level". Specifically, the goals of treatment at Longwood are to:

- Equip residents with the resources necessary to gain insight into the disease concept of alcoholism;
- Internalize their relationship with alcohol/alcoholism;
- Assess its personal consequences; and,
- Teach adaptive skills that will lead to constructive behavioral changes.

The above objectives at Longwood are achieved through a combined process of alcohol assessment, education, and treatment. The assessment process includes standardized resident inventories, structured interviews with the resident, and tests designed to measure alcohol/drug variables, psychosocial data, skill level, and residents' behavioral characteristics.

The aims of education and treatment at Longwood are to: 1) impart information about alcohol; 2) assist residents in recognizing the impact of alcohol in their lives, specifically in reference to drinking and driving, and its effect on society; 3) assist residents in developing constructive alternatives to drunk driving and other self-defeating behavioral patterns; and, 4) help residents assume responsibility for their actions. Longwood residents are strongly encouraged to become involved with the Alcoholics Anonymous (AA) 12 step recovery program, and to develop an AA network, both while in the program at the treatment center, and after release from the facility.

Throughout the brief history of the facility, these goals and objectives have been approached from a variety of perspectives. Although Valle is committed to the utilization of a "Reality Therapy" approach in its assessment and treatment of multiple offenders, they have had to modify their treatment plan to meet the needs of the population served at Longwood. The DOC and Valle at Longwood aim to develop a relationship in which the overall goals of the program, and the particular goals of each of the staffs, coincide with the needs of the population being served.

C. The Staff at Longwood

Formal interviews with staff were conducted between January 1986 through October 1986. Both the Department of Correction and Valle Associates staff were interviewed. The interview schedule, developed by the DOC Research Division, enabled each of the staffs to contribute first hand information relating to the daily operation of the treatment facility. The following is an outline of the contributions each staff make to the Longwood program.

The staff at the Longwood Treatment Center is comprised of an Administration, a Treatment staff which includes both the DOC and Valle counseling personnel, Correctional Security staff, and Business, Clerical, and Maintanence staff.

1. Administration

The Administrative staff at Longwood includes the Superintendent, whose primary duties are supervising, directing and planning for the entire facility. He reports directly to the Commissioner of Correction. The Deputy Superintendent supervises the fiscal, security and treatment components of the Longwood program; the Assistant Deputy Superintendent is responsible for the care, custody and safety of the institution; and, the Director of Treatment supervises all counselors, oversees classification issues, and coordinates the treatment plan in conjunction with the Valle Clinical Coordinator. Together, the above staff oversee the entire Longwood operation to ensure that Department of Correction management, security and treatment objectives are being met.

2. Business, Clerical, Maintenance Staff

The staff of the business, clerical, and maintenance units of the Longwood Treatment Center are responsible, respectively, for monitoring the institutional budget and keeping track of all ledger accounts, performing all clerical details of the institution, and ensuring that the facility operates functionally. The combined staffs consist of a Fiscal Manager, Administrative Assistant, two Senior Clerk typists, three Principle Clerks, a Treasurer, Junior Accountant, and two Correctional Maintenance Workers. The Administrative Assistant, two Senior Clerks, and one Principle Clerk, work directly under the Superintendent, and the Treasurer, Junior Accountant, Principle Clerk, and Maintenance workers report to the Fiscal Manager. The Fiscal Manager at Longwood monitors and documents finances at Longwood.

3. Correctional Staff

Correctional Officers (COs) at Longwood are responsible for maintaining the care, custody, and control of the residents at the Longwood Treatment Center. At the end of the second quarter of 1986, a total of twenty COs were employed at Longwood. This number includes fifteen correction officers, four sergeants, and one lieutenant.

The primary objective of the security staff is to maintain a secure facility for staff, residents, and the surrounding community. To that end, the correctional staff monitor compliance with the rules, regulations and policies of the institution, which are derived from, and consistent with DOC institution policies. Among these, the correctional staff manage the facility Control Room, monitor all movement in and out of the treatment center, conduct resident counts, protect the

facility from the introduction of contraband, administer regular substance abuse checks by urinalysis and saliva tests, conduct strip and pat searches of residents as needed, and document housing evaluations of each resident to convey to the treatment staff for treatment planning.

4. DOC Counseling Staff

When Longwood first opened in March, 1985, the DOC treatment staff, who are under the supervision of the Director of Treatment, consisted of one senior counselor and five correctional counselors. Since December, 1985, two correction counselors and a supervising correctional counselor have been added. The supervising counselor oversees the counseling staff, and schedules all resident classification hearings. As the Director of Treatment's designee, that person often chairs the classification boards and hearings at Longwood.

The responsibility for screening county inmates for admission into the facility presently belongs to the senior counselor and one of the recently acquired correction counselors, neither of whom has a caseload to manage. The screening counselor travels to each house of correction to interview inmates for transfer to Longwood, and the senior counselor supervises the inmate screening and transfer process.

Five of the correction counselors (including one who rotates duties and covers for other counselors) are responsible for managing the caseloads of the entire resident population, in addition to coordinating residents activities within and outside of the institution (ie. furloughs, program related activities (PRA's), work-release etc.). Processing all paperwork relating to residents' movement and activities is a priority, according to the Director of Treatment. Ideally, DOC counselors are expected to meet with their caseloads in individual sessions once per

week to discuss such issues as residents' adjustment to the facility, pending legal issues, parole, furlough, and/or work-release dates, difficulties in focusing on treatment and, if applicable, family problems. Although included as counselors' responsibilities before the facility attained maximum capacity, DOC counselors are no longer able to conduct weekly case conferences with their residents' respective Valle counselor. Although not included as a component of their job description, DOC counselors frequently act as court transports, and/or messengers if security or other staff people are unavailable.

In addition, one counselor acts as a group monitor. This person is scheduled to network with outside support groups in an effort to obtain speakers for Longwood-hosted AA, Narcotics Anonymous (NA), Alanon etc. meetings on site at the facility on designated evenings. The monitor works collaboratively with a Valle counselor in carrying out these duties.

The seventh DOC counselor, in addition to often managing a small caseload, acts as the Longwood aftercare coordinator, and is responsible for conducting both phone and personal interviews with all residents who have been discharged from Longwood with the intention of determining program effectiveness in terms of released residents' sobriety and post-Longwood drinking behaviors.

Most of the above correctional counseling staff has background experience in either criminal justice or counseling or both, although not all are experienced as such. Particular knowledge or experience in alcohol-related counseling is not required, although it is welcome.

5. Valle Treatment Staff

By October 1986, the Valle staff was comprised of a Clinical Coordinator, Secretary, part-time Supervisor, two senior counselors, four Phase I counselors,

two Phase II counselors, and an additional part-time counselor. Throughout the history of the Longwood Program, Valle has undergone periodic staff changes at Longwood. With the treatment plan changing to meet the needs of an increasing population, the duties of the counseling staff, similarly, have changed.

At present, Valle counseling staff responsibilities entail disseminating educational information about alcoholism through lectures and discussions, leading Phase I and Phase II therapy groups, providing one-on-one counseling to residents as needed, and in general, supplying residents with the tools to embark on the road to alcoholism recovery. In the program description, the role each of the Valle counselors plays toward the actualization of those objectives will be discussed in detail.

The supervising staff of Valle are responsible for overseeing staff growth, payroll, and program progress. The clinical coordinator ensures that the treatment goals and objectives at Longwood are being met, and the supervisor assists the treatment staff in dealing with the particular incarcerated alcohol offender at Longwood through continual staff training. The senior Phase I and II counselors monitor and evaluate the Phase I and II programs, and manage case conferences of Phase I and II staffs, in addition to conducting lectures and leading discussions in their particular phases.

Valle prefers that the counseling staff at Longwood be Certified in Alcohol Counseling (CAC). As of October 1986, eight of the thirteen Valle treatment staff had their CACs. Although not all Valle staff at Longwood have personal experience with alcohol and/or other chemical dependencies, Valle Associates make it a policy to try to recruit counselors who do, the stated philosophy being that such a staff may offer clients a particular perspective with which the clients can identify. Although counselors with a Master's degree in alcohol or other counseling education are preferred, personal experience with alcoholism is often

substituted and has been used in the past to support the hiring of staff members without the preferred education. Further, very few Valle staff members at Longwood have past experience in the criminal justice system, or experience working in a locked correctional facility, although some have worked as counselors in the second offender residential alcohol rehabilitation facilities established under the 1982 law.

D. Chapter Summary

From the perspective of both the DOC and Valle at Longwood, the treatment component of the program is based on the philosophy that alcoholism is a complex, multidimensional illness that must be understood in the context of an individual's drinking history, personality, environment and skill level. To that end, the goals of the program, stated broadly, are to expose residents to the disease concept of alcoholism, and to introduce them to adaptive skills that will ultimately lead them to constructive behavioral changes. The above objectives are achieved through a combined process of alcohol assessment, education, and treatment.

The staff at Longwood is unique in that it is comprised of both contracted private treatment providers and DOC personnel working cooperatively. Specifically, the Longwood staff consists of a DOC administration, counseling staff, business and maintenance staff, and correctional personnel. The Valle staff consists of both clinical supervisors and direct care providers. Together, the two staffs work toward the aforementioned goals.

V. THE POPULATION SERVED AT LONGWOOD

To address the research questions pertaining to the type of inmates participating in the Longwood program, Section V describes the population of OUI inmates at Longwood. This section examines the recruitment and selection methods by which county OUI inmates are transferred into the Longwood program, the number and type of clients utilizing the project services, and compares Longwood participants with other state and county inmates.

The following section is divided into six subsections which will: a) highlight the debate over the characteristics of drunk drivers in general; b) discuss the screening and transfer procedures at Longwood; c) summarize the results of a DOC study aimed at targeting eligible county OUI inmates for transfer to Longwood; d) discuss changes in the screening process; e) analyze Longwood participants as they compare to other state and county commitments; and, f) investigate indices of alcohol impairment among Longwood residents.

A. Characteristics of the Drunk Driver

The extent to which multiple OUI offenders incarcerated in county houses of correction differ from their non-OUI incarcerated counterparts is the subject of considerable debate. The controversy centers around a number of issues, one of which is the criminality of repeat OUI offenders in comparison with non-OUI offenders, and another, the rate of problem drinking among repeat OUI and non-OUI offenders.

Upon interviewing county correctional administrators, Massachusetts Department of Correction researchers discovered that many county officials

mentioned differences they observed between the incarcerated OUI offender and the typical county inmate, although the perceptions of their characteristics were not unanimous among those authorities (Moore, 1985). Three factors emerged in reference to distinguishing between the two types of county populations:

1) Differences in background and social characteristics of the two types of inmates;
2) The non-criminal nature of the OUI offender; and,
3) The seriousness of alcohol abuse among OUI offenders.

Although there was general agreement among county administrators that the level of alcohol abuse was high among repeat offenders incarcerated in their facilities, there was some disagreement over the contention that the OUI offenders were "non-criminal". A joint study by the Massachusetts Office of the Commissioner of Probation and Division of Alcoholism, reported that 64.4% of the entire arraigned OUI population in 1983 had previous involvement with the criminal justice system (Brown et. al., 1984). County administrators who supported the claim that OUI offenders were different from non-OUI offenders defended their position by maintaining: 1) the criminal histories of OUI offenders were usually limited to traffic or alcohol related offenses; and/or 2) the offenses stemmed from an alcohol problem (Moore, 1985). However, other county officials argued that it is not unlikely that individuals charged with both motor vehicle theft and OUI could plea bargain the charge and serve time for the OUI, thus appearing to be non-criminal.

Disagreement among these county authorities is reflective of the larger debate in general. As is evident from the 1982 amended OUI statues, Massachusetts has sought to reconcile the two perspectives with a combination of

treatment and incarceration. Consistent with the recommendations of the Presidential Commission on Drunk Driving (1983), researchers point out, "treatment in Massachusetts is viewed as a supplement to and not a substitution for legal and administrative sanctions" (Forcier et. al., 1986: 1216).

In reference to Longwood, these overall concerns for differentiating problem drinkers from other county offenders in order to develop a treatment plan, have repeatedly surfaced in program planning and implementation. With the intention of profiling the population serving time at Longwood and addressing some of these issues, the following section is divided into three components. First, we examine some of the issues manifested in the screening and transfer of appropriate residents to Longwood. Second, we compare Longwood residents in the program in 1985 to other county and state offenders for that same year. Third, we examine the level of alcohol abuse among the Longwood population.

B. The Screening and Transfer Procedures at Longwood

The early stages of the Longwood operation were beset with difficulties in the screening and transfer of county OUI inmates to the state-run treatment center. The list of provisos mandated by the Boston Zoning Board and mentioned in an earlier chapter, essentially restricted the population of county offenders able to be diverted to the regional treatment centers, and such limitations were not anticipated by the initial program planners. Consequently, the development of a specific treatment plan to meet the needs of the population was slow and complicated, as was the early screening and transfer process itself. Moreover, the Massachusetts judiciary, legal community, and county governments were, for the most part, uneducated about the existence of the new Longwood program, and therefore were not aware that repeat offenders with apparent alcohol abuse

problems were able to receive intensive treatment in a minimum security facility such as Longwood. Although judges cannot sentence offenders to Longwood directly, they can assign an offender a penalty within the mandatory sentencing range, and recommend that the offender transfer to Longwood to serve the sentence there, providing that offender meets the criteria set forth in the provisos.

The provisos, the unfamiliarity with Longwood on the part of the legal and criminal justice community, and the early screening and transfer model itself led to an often disorganized process of first admitting residents into the Longwood program. In fact, although there was a sufficient number of eligible residents to begin program operation early in 1985, doubts were raised among Longwood administrators about the feasibility of attaining full capacity of 125 residents with the limits placed on offenders with prior criminal histories and pending warrants, or those assigned to weekend sentencing. A Department of Correction researcher was assigned to assist the Longwood administration in designing an effective screening procedure by examing two houses of correction, Billerica and Dedham, in order to target the population of OUI offenders to be served at Longwood, and provide a sample basis by which to screen offenders from other county houses of correction within the Longwood jurisdiction. Below is a summary of the result of that undertaking.

C. County Commitments for Operating Under the Influence of Alcohol in the Process of Transfer to the Longwood Treatment Center: A Sample Population

The researcher first examined the transfer process whereby county commitments for OUI at Billerica and Dedham were determined eligible for the Longwood program, and then focused on the actual transfer of those inmates to

Longwood. The data used to determine the offender's eligibility included the offender's governing offense, sentence, age, race and residence at the time of commitment. The residents' eligibility criteria were checked through Longwood records, county institutional records, probation, and FBI records. These variables in total were examined to determine if they shed any light on the characteristics of offenders undergoing transfer to Longwood. The screening and transfer processes utilized by Longwood staff from March 1985 through December 1985 were highlighted in this examination of the two county houses of correction. Modifications in the screening and transfer procedures since this subsection of the study was completed in December, 1985 will be examined following the summary of the results.

1. Eligibility Criteria

The criteria used to determine the offender's eligibility in this process of selection and transfer during the period under consideration fall into two general categories: the Legal and Community-Related criteria contained in the Boston Zoning Board's decision to permit the opening of the Longwood Treatment Center and the Department of Correction's policies on Program-Related criteria.

According to the Legal and Community Related criteria already discussed, the principal criterion for placement at Longwood is offense: the offender must have a governing offense of Operating Under the Influence of Liquor. OUI offenders with fines or weekend sentences are ineligible for Longwood because the treatment program is designed as a residential program. Offenders with a record of prior incarcerations for violent offenses, with concurrent violent offenses, or with outstanding warrants for violent offenses, are not eligible due to the concern of the community over safety issues. Other eligibility criteria, such as a maximum

of 36 months to parole eligibility and no medical or detoxification needs, may render an offender ineligible but did not affect the Billerica and Dedham data.

The Program-Related criteria were established by policies of the Department of Correction and center around sentence length and prior institutional behavior. The Longwood Treatment Center program is designed for a minimum residential stay, and therefore there is a preferred minimum sentence requirement of 60 days. Because county offenders are typically eligible for parole after serving half of their sentence, 60 day minimum sentences allow residents to spend at least 30 days in the Longwood program. Thus, the preferred minimum residential stay at Longwood during this study period was 30 days.

Because of the treatment-oriented atmosphere at Longwood, offenders are considered ineligible for placement if they have received disciplinary reports while incarcerated in the county. Similarly, due to the relatively more relaxed security arrangements (compared to most county houses of correction), offenders with a prior history of attempted or actual escapes are considered ineligible for placement at Longwood.

Offenders with outstanding warrants are considered unsuitable for placement at Longwood until the warrant is resolved. After the warrants are resolved, the offender is considered for transfer as long as the new (warrant) offense does not result in a change of governing offense from OUI to another offense.

After it is determined that the offender meets the criteria and is eligible for placement at Longwood, the offender has the choice of transferring. The program is designed for voluntary participation. Those offenders who volunteer for placement at Longwood sign an agreement to participate in alcohol treatment.

2. Results of The Sample Examination

Of the 562 OUI commitments to Dedham and Billerica houses of correction from March through December 1985, 86 (15%) were transferred to the Longwood Treatment Center. The remainder of the OUI commitments were found to be ineligible at some point during the screening and transfer process or were dropped at some point even though they appeared to be eligible.

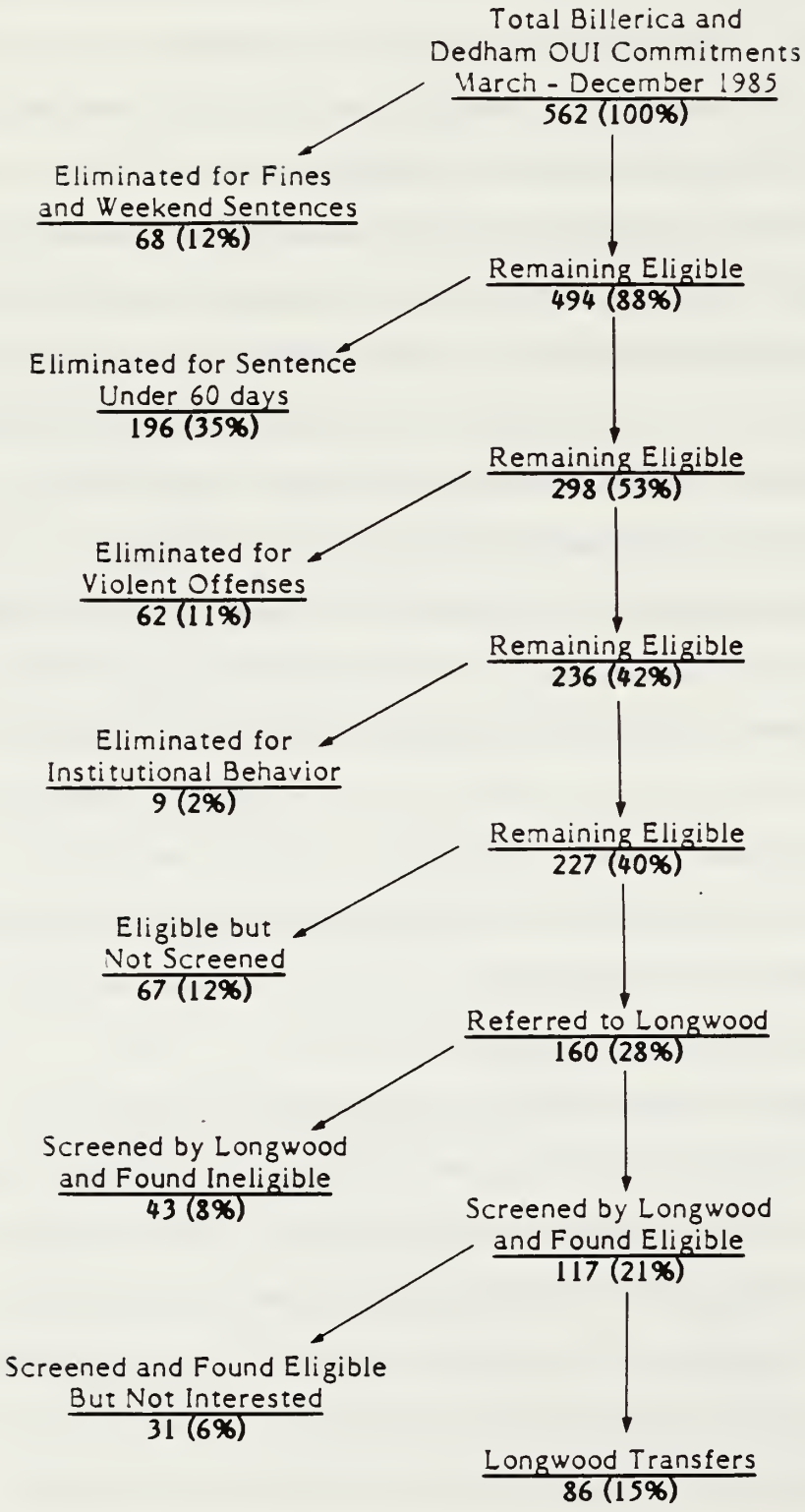
Of those 562 OUI commitments, 68 (12%) were eliminated due to fines and weekend sentences; 196 (35%) were eliminated for having sentences of less than 60 days; 62 (11%) were eliminated due to violent offenses (prior, concurrent or warrants); and 9 (2%) were eliminated due to institutional behavioral problems.

Of the 227 (40% of total commitments) offenders not eliminated up to this point, 67 (30%) were not screened by Longwood staff even though no reason for elimination could be discovered. Of those same 227 apparently eligible offenders, 160 (70%) were screened for Longwood. Of those 160 screenings, 43 (27%) were screened by Longwood but found to be ineligible at the time of screening. For example, some of the above were found to have outstanding warrants, or had problems getting proper records in time, thus rendering them ineligible for transfer. Of the remaining 117 inmates, 31 (26%) were screened and found eligible, but were not interested in transferring, and 86 (74% of screened offenders) were accepted into and transferred to Longwood.

The demographic variables examined included age, race and residence. For the total sample of 562 OUI commitments, the median age was 27 years, 96% were white and the majority of offenders committed to each county resided in that county. Of these demographic variables, the only difference which showed up was that all blacks who appeared to be eligible for Longwood were screened, though the numbers were too small to show statistical differences. The following flow chart depicts the transfer process for the Billerica and Dedham OUI commitments.

Figure 1

Flow Chart of Transfer Process



D. Problem Areas in the Screening Process: Staff Perspectives

1. "Short Termers" Disrupt Treatment

Numerous changes were made in the screening procedures following completion of the examination just presented. In addition to the contribution made in the delineation of the screening and transfer process, interviews with both Longwood staff and residents unearthed other perspectives relating to the transfer of appropriate residents to Longwood, and similarly, affected modifications in screening policies.

Both staff and residents interviewed by DOC researchers between January and October 1986 were critical of the screening process employed in the first year of the Longwood program operation (March 1985 - March 1986). The most common concern voiced was in reference to a resident's length of stay in the program. The administration, DOC counseling staff, Valle treatment staff, security staff, business staff, and residents themselves were unanimous in their opinion that the major program limitation was the preferred sentence requirement of 60 days. Because county offenders are typically eligible for parole after serving half of their sentences, some of the county inmates transferring into the Longwood program with 60 day sentences are eligible for release after only 30 days, (sometimes sooner if their actual transfer to Longwood was delayed). These "short termers", as both the staff and residents referred to them, disrupt treatment. With treatment at Longwood designed in phases with particular lengths of stay for each phase, those in the program for less than thirty days are only superficially exposed to the extensive treatment available. A number of Valle staff members interviewed however, suggested that at least minimal exposure to basic alcohol education is preferable to the none or little offered in the counties.

Further, the somewhat experimental screening and transfer process itself caused delays in the actual transfer of inmates to Longwood in the first year of program operation. For example, because of delays in obtaining information such as criminal history and warrant checks, (due to numerous factors such as the reliance on an outside Law Enforcement Agencies Processing System (LEAPS) terminal and the lack of education about the Longwood program evinced among criminal justice professionals), the turn-around time from an actual screening to the receipt of appropriate information for each potential resident ranged from one day to three weeks. As a result of such delays, residents with stays at Longwood of less than 30 days were common among the total population. Again, both staff and residents commented that short termers challenged the program's treatment goals. Specifically, both staff and some residents interviewed claimed that short termers were less interested in realizing treatment than in doing time. According to a number of residents interviewed, these were also often the residents who had "poor attitudes" toward treatment, and "ruined it for others". As a remedy, all staff people interviewed recommended raising the minimum length of stay at the Longwood facility itself to 90 days.

2. Low Level of Commitment to Treatment Among Some Residents

Another concern voiced by the staff interviewed in reference to screening concerned the need for better detection of "unmotivated" residents before they entered the Longwood program. Although as has been discussed, lack of motivation toward treatment was often attributed to the fact that residents with short sentences were admitted into the program, other residents as well proved to be uninterested in treatment once in the Longwood program. Both Valle and the DOC Treatment staff maintain that participation in treatment is an essential element of

a successful stay at Longwood. The residents themselves noted that success in the program is dependent upon an individual's willingness to participate and residents without incentive negatively impact treatment. First, it was said that unmotivated residents diverted the attention of the treatment staff away from actual treatment. For example, one Valle counselor mentioned the impact on treatment of "wearing two hats", that of a therapist and that of a disciplinarian. Second, counselors from both the DOC and Valle staff maintained that the program is too costly to have in it residents without the desire to be there.

Another group of residents who negatively impacted treatment surfaced periodically in the first year of program operation. These were Longwood residents who, according to both the DOC and Valle staff interviewed, "slipped through the screening process", and who technically did not belong in the Longwood program. In addition to residents enrolled as "short termers", ocassionally residents with apparent medical or psychiatric problems were admitted into Longwood and, in addition to violating the terms of the provisos set forth by the Boston Zoning Board, the facility was not staffed with the appropriate professionals to address such clients' needs.

Other Valle staff members mentioned the possibility that clients at Longwood had been surreptitiously drinking or taking drugs just prior to entrance into Longwood, or possibly while at the Treatment Center, and therefore were "detoxing" at Longwood. This, it was stated, not only made treating those participants impossible, but also set a negative example for other residents more serious about treatment.

Although there was consensus among staff and residents in reference to the need to improve the screening process so as to funnel into the program only residents who desired alcohol education and therapy, and filter out those who were not eligible or who would not benefit from the program, most of the staff members

interviewed admitted that it was difficult for a screening person to detect sincerity on the part of county inmates. Both the staff and residents interviewed, however, advocated the need for a revision of the screening procedures, with the DOC and Valle treatment staff stating that in order to develop a treatment plan aimed at a certain population, the population needed to be relatively predictable, motivated, and cooperative.

3. Changes in the Screening Process Since December 1985

In response to the aforementioned difficulties encountered in the screening process in the first year of the Longwood operation, changes were made in the screening procedures.

First, in March 1986, a screening counselor with sole responsibility for interviewing residents at the county houses of correction and MCI-Framingham, was added to the DOC treatment staff, relieving the DOC counselors with caseloads and other responsibilities at Longwood of this duty. Presently, the screening counselor either phones the houses of correction or MCI-Framingham, or is notified by them in order to organize a time and day for the counselor to interview apparently eligible county inmates. Staff at most county facilities, aquainted with the Longwood program through education efforts on the part of the DOC and Longwood administrators, inform eligible OUI inmates about the existence of the Longwood program in order that they can consider the possibility of transfering there should they meet the stipulated criteria. One county house of correction, in fact, posts a description of the Longwood program in a common area where inmates congregate. Presumably, then, most county OUI inmates slated for interviews with the screening counselor are familiar with the requirements of the program before the screening counselor arrives at the county facility.

Second, the screening questions themselves have been modified with the intention of distinguishing potentially motivated and unmotivated residents. Valle staff and the DOC treatment staff at Longwood worked collaboratively toward refining the screening questions to differentiate residents with a sincere commitment to addressing their alcohol abuse from those who were primarily interested in serving time outside of their respective facility of origin. For example, the new screening form asks questions in direct reference to alcoholism and alcohol's impact on the inmate and/or his or her family, and its general effect on society. For instance, instead of asking the resident, "do you consider yourself to be a social drinker?", as was the case on the original screening form, the new questionnaire asks, "how do you know you have a drinking problem?", "how could you benefit from the Longwood program?", "define alcoholism", and "how do you think alcoholism should be treated?". The responses to these questions presumably separate out inmates who are sincere about receiving treatment and who recognize their own alcohol abuse problem from those who do not. In addition, potential residents interviewed under the updated screening guidelines are asked to sign a statement consenting to communication between the Longwood Treatment Center staff and any court, probation/parole department or other agency as needed for aftercare and follow-up purposes upon release from Longwood. In the initial screening procedures, potential residents were required to agree to participate in aftercare, but were not informed that their parole or probation officer (if applicable) would be notified if they did not maintain contact with the aftercare coordinator at Longwood. Agreement to participate in an aftercare program is a condition for acceptance into the Longwood program under the revised screening procedures.

As was the case with the initial screening methods, residents are asked questions pertaining to their criminal histories and pending warrants, and are rated

by the screening counselor on a scale from one to five. Presently, however, the screening counselor is cautioned to pay particular attention to such things as the interviewee's attitude, behavior, motivation, and desire for recovery. Under the new screening guidelines, a counselor or supervisor from the Valle treatment staff is scheduled to accompany the screening counselor to one house of correction per week with the intention of providing feedback on a person's potential for treatment. Although researchers did observe a screening with both a Valle and DOC counselor, Valle staff did not participate in screenings once per week as was planned.

Although no policy has been established to extend the minimum length of a resident's stay at Longwood to ninety days as was suggested by many of the staff interviewed, aquisition of a LEAPS terminal for the Longwood premises, educating the counties and criminal justice professionals about the Longwood program, and assigning one counselor to conduct screenings, have all contributed to a refinement of the screening procedures. Consequently, these factors have shortened the time it takes between a resident's screening and admission into Longwood.

In addition, the inclusion of screening questions specifically pertaining to alcoholism, the input of the Valle staff for detecting potentially unmotivated clients, and better detection of inmates with medical or psychiatric needs, have led to what both Valle and DOC staffs refer to as a more organized, coherent, and consistent screening process. Thus, more motivated participants are admitted to the Longwood program.

E. Statistical Analysis of Longwood Treatment Center Residents During 1985

This section defines the characteristics of the Longwood population during 1985 including a comparison between Longwood residents and all court

commitments to both state and county institutions in 1985. Specifically, 1985 Longwood commitments were compared to three other populations: 1) other 1985 county OUI commitments; 2) total 1985 county commitments; and, 3) 1985 state commitments. In order to identify differences among these populations, the populations were compared across sociodemographic and sentencing variables. The sociodemographic variables include: sex, race, age at commitment, education, marital status and residence by county. Sentence variables include: present offense, county from which committed, sentence length and sentence type. The four populations are described, compared, and summarized in Table V.1 below through the presentation of the frequency distributions of these variables.

1. Sociodemographics

Sex: Men constituted 88% (189) and women 12% (26) of the Longwood population. In contrast, men constituted 99% (2,114) of the county OUI population and 99% (9,491) of the total county population while women constituted less than one percent of the county OUI population and less than one percent of the total county population. The higher percentage of women at Longwood is attributable to the fact that Longwood is a co-ed facility and county facilities are predominantly male with the exception of Franklin, Berkshire, Dukes, and Hampden counties. Women sentenced to a county jail or house of correction are incarcerated at MCI-Framingham which is partly reflected in the fact that women represented 33% (799), and men 67% (1,610) of the DOC commitments in 1985.

Race: Ninety-two percent (199) of the Longwood admissions in 1985 were white which is identical to the proportion (1,944) of county OUI commitments who were white. Blacks represented only 5% (10) and hispanics 2% (5) of the Longwood

admissions which is similar to their representation among county OUI commitments where blacks constituted 4% (89) and hispanics 3% (54) of county OUI commitments in 1985. By contrast, there was a lower percentage of whites, among total county (77% or 7,341) and state DOC (61% or 1,474) commitments in 1985 and a higher percentage of both blacks and hispanics where blacks represented 14% (1,288) and hispanics 6% (528) of county commitments, and blacks constituted 27% (660) and hispanics 11% (261) of DOC commitments.

Mean Age at Commitment: The mean age of Longwood residents at commitment was 32.7 making them, on average, the oldest of the four populations compared here. The mean age of the county OUI population was 31.3, while the mean age for the total county and DOC populations was 28.3 and 29.1, respectively.

Education: The Longwood population is more highly educated than any of the comparison populations. Almost three-quarters of the Longwood population, 72% (154), received their high school equivalency or better, compared to 62% (1,310) of county OUI commitments, 49% (4,659) of total county commitments, and only 38% (910) of DOC commitments. Moreover, 17% (36) of the Longwood population were college graduates compared to only 3% (56) of the county OUI, 2% (158) of the total county, and 2% (41) of the DOC populations.

Marital Status: Only 19% (41) of the Longwood residents were married which is similar to the other groups where 24% (506) of the county OUI commitments, 18% (1,704) of the total county, and 18% (425) of the DOC population were married. Eighty percent (171) of the Longwood residents were either single, separated, divorced, or widowed compared to 76% (1,612) of the county OUI, 82%

(7,801) of the total county, and 82% (1,978) of the DOC populations.

Residence: Of the 215 transfers to Longwood in 1985, 31% (66) were from Middlesex County, 16% (35) from Norfolk county, 10% (22) from Plymouth county and 9% (20) from Suffolk county accounting for 66% of the total Longwood population during 1985. Comparatively, Middlesex, Worcester, Essex, and Norfolk counties accounted for 57% (1,215) of the total 2,118 county OUI commitments in 1985. Middlesex, Worcester, Suffolk and Hampden counties accounted for 58% (5,472) of the total county and 70% (1,691) of the total DOC commitments in 1985. By itself, Middlesex county contributed the largest portion of residents to each group, with 31% (66) of Longwood, 24% (499) of the county OUI, 18% (1,674) of the total county, and 14% (350) of the DOC populations, originating from Middlesex County.

Table V.1

Selected Characteristics of Longwood Treatment Center, County OUI, Total County, and State DOC Prison Populations During 1985

Characteristic		Population			
		Longwood (N=215)	County OUI (N=2,118)	Total County (N=9,511)	State DOC (N=2,409)
Mean Age		32.7	31.3	28.3	29.1
Percent Male		88%	99%	99%	67%
Percent Female		12%	1%	1%	33%
Race:	White	92%	92%	77%	61%
	Black	5%	4%	14%	27%
	Hispanic	2%	3%	6%	11%
Marital:	Married	19%	24%	18%	18%
	Single	81%	76%	82%	82%
Received High School Diploma or Better		72%	62%	49%	38%

2. Sentence Information.

Present Offense: All Longwood residents served time for an OUI conviction and 3% (6) served time for vehicular homicide as well as a multiple OUI conviction. No Longwood resident was admitted to the program on a present sex, drug, or property offense. Eighty-seven percent (8,245) of the county residents served time for a non-violent offense and 13% (1,266) served time for a violent offense. By contrast, 45% (1,082) of all DOC residents served time for a violent offense and 55% (1,327) served time for a non-violent offense.

Court From Which Committed: Thirty-five percent (76) of Longwood residents were originally committed to a house of correction from a Middlesex court. Norfolk County courts committed 19% (40), Plymouth County courts committed 13% (29) and Worcester County courts committed 8% (17). Together, these four counties constituted 75% (162) of the Longwood commitments. Similarly, Middlesex County committed the highest number of county OUI residents at 24% (517). Worcester County committed 14% (293), Essex County committed 13% (279), Norfolk County committed 11% (234), and Hampden County committed 9% (183) of the county OUI residents. Together, these five counties constituted 71% (1,506) of the county OUI residents. Similarly, Middlesex County committed the highest number of total county residents at 20% (1,916). Worcester county committed 15% (1,452), Suffolk County committed 12% (1,176) and Hampden County committed 10% (930) of the total county residents. Together, these four counties committed 58% (5,474) of the total county residents. However, Suffolk County committed the highest number of DOC residents at 28% (676). Middlesex County committed 18% (433), Worcester County committed 16% (389) and Hampden County committed 9% (227) of all DOC residents. Together, these four

counties committed 72% (1,725) of all DOC residents.

Sentence Length: Eighty-seven percent (188) of the Longwood residents served a year or less at Longwood. Similarly, 93% (1,981) of county OUI residents and 80% (7,571) of the total county population served a year or less in a county house of correction. By contrast, only 3 (less than 1%) males in DOC institutions served a maximum sentence of one year or less.

Sentence Type: Forty-six percent (98) of Longwood residents were given either a simple sentence, 36% (78) a concurrent sentence, or 14% (30) a split sentence. Similarly, 35% (836) of DOC residents were given either a simple sentence, 35% (839) a concurrent sentence, or 14% (333) a split sentence. There were no statistics available for sentence type of county OUI residents and total county residents.

F. Alcohol Impairment Among Longwood Residents

Ideally, the assessment of alcohol impairment typically relies on three indicators: 1) volume of absolute alcohol consumed (i.e., ethanol consumed per typical drinking day over some period of time, usually past 30 days); 2) number and types of alcohol dependence symptoms (i.e., blackouts, hallucinations, loss of control over drinking experienced over past 30 days); and, 3) number and types of adverse consequences due to drinking experienced over past six months which are of three types: health (i.e., alcohol-related hospitalization or illness); law enforcement (i.e., arrested for OUI, arrested for non-OUI alcohol-related offense); and, work and interpersonal relations (i.e., not currently employed because of drinking problem, got into fights or arguments with others while drinking). In the

absence of these measures, ascertaining the level of alcohol impairment among a population is more difficult and relies on impressionistic evidence.

Many would argue, with good cause, that repeated arrests and convictions for OUI is sufficient evidence to infer at least a serious drinking problem if not outright alcoholism manifested by physiological and psychological addiction, and loss of control over drinking. Since Jellinek's (1952, 1960) work on phases of alcohol addiction and the disease concept of alcoholism, the clinical diagnosis of alcoholism has become increasingly refined although still the subject of considerable debate. In this study, personal assessments made by both the DOC and Valle staff working with the residents at Longwood, the residents' own perceptions of their drinking behaviors, and an investigation into the prior treatment experiences of Longwood residents released through mid-1986 were used to formulate a composite picture of the typical drinking behaviors of Longwood residents. The following section examines these criteria for assessing the level of alcohol impairment of the Longwood population, and examines whether or not the levels of alcohol abuse among past and present program participants is distinguishable.

1. Previous Treatment Experiences of Released Longwood Residents

The following tables and summaries profile the prior treatment experiences of Longwood residents released from the program from April 1985 through July 1986. The information was obtained from each resident's DOC file. Table V.2 presents the number of prior treatment experiences of released Longwood residents.

Table V.2

Number of Prior Treatment Experiences (including AA)
of Longwood Residents Released from April 1985 - July 1986

Frequency	Number of Experiences	Percentage
None	42	13
One	104	31
Two-Three	176	52
Four-Five	15	4
TOTAL	**337**	**100**

In total, 295 out of 337 (88%) residents had prior experience with alcohol treatment. Over one half, 176 (52%), had two to three previous experiences with treatment. Over one fourth of the Longwood residents 104 (31%), had one prior treatment experience. However, only 42 (12%) of the Longwood residents studied had no prior experiences with alcohol treatment. In addition, only 15 (4%) of the released Longwood residents examined had four to five prior experiences with treatment. There were no Longwood residents that had more than five past experiences with treatment. The mean number of prior treatment experiences was two. For purposes of this research, Alcoholics Anonymous (AA) meetings constitute prior treatment experiences.

Table V.3 examines the settings of treatment programs Longwood residents with prior treatment experiences participated in. Seven different settings of treatment programs were attended by Longwood residents: 1) first offender programs - court ordered; 2) second offender programs - court ordered; 3)

residential treatment (Massachusetts); 4) non-residential treatment (Massachusetts); 5) halfway houses (Massachusetts); 6) out-of-state treatment; and, 7) Alcoholics Anonymous meetings.

Table V.3

Setting and Number of Prior Treatment Programs Represented Among Longwood Residents Released from April 1985 - July 1986

Type of Treatment Program	Number
First Offender Program-Court Ordered	21
Second Offender Program-Court Ordered	5
Residential Treatment (Massachusetts)	31
Non-Residential Treatment (Massachusetts)	27
Halfway Houses (Massachusetts)	19
Out of State Treatment	13
Alcoholics Anonymous Meetings	122
Other	30
TOTAL	**268**

For the 295 residents with one to five experiences with treatment, 268 episodes of treatment across seven settings, including AA, were utilized. Presumably because of its availability as a resource, 122 different AA meetings were cited by residents with prior exposure to treatment. There were 31 residential treatment facilities used, including programs operated by NORCAP, MARCAP, Mt. Pleasant, and Naukeag Hospital. There were 30 treatment programs mentioned by residents with prior treatment experiences that were not listed in the Massachusetts Directory of Alcohol and Drug Treatment Programs

(Massachusetts Bar Association; 1985-1986). Some of these included Melville Towers, Alcap, DART, DIAL, Step Inc., and Phoenix. There were 27 non-residential treatment programs cited, including programs operated by Valle Associates, Bancroft Human Services, Chelsea Alcohol Safety Action Projects (ASAP), and McClean Hospital. Twenty-one first offender programs were used by released Longwood residents with prior treatment experiences. Some of these first offender programs were run through Lowell General Hospital, Billings Human Services, Alcohol Services of Greater Springfield, and Valle Associates. Nineteen halfway houses were utilized by residents with past treatment. Among those cited were Gavin House, Flynn House, North Cottage, and Steppingstone. Thirteen out-of-state treatment centers, including Edgehill, Beech Hill, Seminole Point, and Spofford Hall, were cited by residents with past exposure to treatment. Finally, five second offender programs were represented among the total types of treatment realized by residents with prior experience. Currently, there are three such programs in operation within Massachusetts: Rutland; Lakeville; and Middlesex County.

2. Staff Perceptions of Alcohol Abuse Among Longwood Residents

Longwood staff interviewed between January and October 1986 were asked to assess the level of alcohol impairment among the residents in the program to determine the level of alcohol abuse among the population they were dealing with, and also to assess whether or not the past and present residents differed in terms of alcohol impairment. Below is a summary of the most salient observations made by the Administrative, DOC treatment, and Valle treatment staff.

The Longwood Administrative staff considered the level of alcohol abuse among the residents in the program to be "serious". The staff contended that the

residents displayed problems attributable to heavy drinking, and they blamed the residents' past criminality on their consumption of alcohol. Many argued that the very fact that Longwood residents had multiple convictions for OUI was sufficient evidence to indicate an alcohol problem.

The DOC treatment staff unanimously maintained that most residents were either heavy substance abusers or at the beginning stages of a very serious problem. Some DOC counseling staff noted changes in the level of alcohol abuse among past and present residents. For example, one counselor commented that "lately" (mid-1986), more residents appeared to be doubly addicted to both alcohol and drugs, and demonstrated criminal histories involving heavy drug as well as alcohol use. Another counselor mentioned that the treatment center goes through phases where the level of abuse among new residents is higher than at other times, and suggested that the level of abuse may appear higher at present because the screening procedures have been refined to admit only those residents who acknowledge their alcoholism.

The Valle treatment staff estimated that between 95-100% of Longwood residents were chronic alcohol abusers in the mid to late stages of alcoholism. Any exceptions they made to this assessment were in reference to residents in the program who were committed for Motor Vehicular (MV) Homicide. It is possible, some Valle staff claimed, that residents convicted of MV Homicide may not be alcoholics, if it were the first time the resident was convicted of driving drunk. In contrast to DOC counseling staff, Valle staff stated that there is no difference in the level of alcohol abuse among past and present program participants. The staff commented that many of the residents come from families with histories of alcohol abuse, and that any record of violence or other aggressive behaviors are attributable to their alcohol consumption. One staff member charged that the female offender at Longwood is in general, "sicker" than the male, and has other

very serious problems in addition to her alcoholism (such as guilt associated with being an alcoholic mother). Lastly, the Valle staff asserted that most of the residents receiving treatment at Longwood had escaped alcohol treatment in the past, an assessment that is at odds with the investigation into released residents' prior treatment involvement presented earlier in this section.

3. Residents' Perception of Their Own Alcohol Abuse

One hundred Longwood residents were interviewed by a DOC researcher between March 1, 1986 and June 6, 1986. The residents interviewed were asked to what extent, if any, they considered themselves to be alcohol abusers and whether or not they had attended previous treatment programs and/or participated in AA prior to coming to Longwood. The intent of the questions was to gain some sense of the extent to which Longwood residents recognized their problem with drinking by both asking them directly if they were alcoholic as well as asking them if they sought help for their drinking in the past.

Eighty-five (85%) of the residents queried perceived themselves as having a serious drinking problem and/or saw themselves as alcoholic. Most of the remaining 15 (15%) residents claimed that while they had some sort of a drinking problem, they were not certain that they were in fact alcoholic, and were reluctant to define themselves as such.

In terms of prior experience with treatment, 59 (59%) claimed to have participated in at least one treatment program prior to coming to Longwood. For purposes of this analysis, attendance at AA meetings constitutes involvement in treatment, but the court ordered participation in the eight week first offender driver alcohol education program does not. Court ordered attendance at residential programs such as Rutland, however, are counted as previous treatment.

Further, many of the residents interviewed who did not define themselves as alcoholics claimed that the staff at Longwood insists that every resident at the treatment center is an alcoholic, and some maintained that AA is "pushed" on them at the facility.

G. Chapter Summary

Based on the information just presented, the most common resident at the Longwood Treatment Center is a white single male between the ages of twenty-six and forty years old, high school educated, and most recently employed as a manual laborer. He is serving his present sentence of less than one year for a third OUI, and is likely a transfer from Middlesex, Norfolk, Plymouth, or Worcester County.

In reference to alcohol abuse, 85% of Longwood residents interviewed before July 1, 1986 consider themselves to be alcoholics. Staff interviewed however, place the figure higher, asserting that 95-100% of Longwood participants are in the mid to late stages of alcoholism.

In terms of past experiences with alcohol treatment, between 57% and 73% of the one hundred Longwood residents interviewed before July 1, 1986 had at least one prior treatment experience before entering Longwood. Similarly, 293 out of 337 residents released from Longwood from April 1985 to July 1986 had prior experience with alcohol treatment with over one half of these having participated in past treatment programs two to three times.

VI. A DESCRIPTION OF THE LONGWOOD PROGRAM IN OPERATION: RESIDENT MOVEMENT FROM ADMISSION TO RELEASE

This section describes the Longwood program in operation and addresses the question of what happens in the program in order to further examine program implementation. The information presented in this section was gathered from direct observation of program services, staff meetings and group therapy sessions, as well as from unstructured observations of informal interactions and unplanned activities, and utilization by researchers of facility services such as the cafeteria and coffee wagon. The following section is divided into six subsections which will examine client movement through the program from admission to release, including a description of the aftercare component of treatment.

A. Admissions and Orientation

When the OUI offenders arrive at Longwood, they bring with them all paperwork (mittimus, medical history, security information, etc.) and all personal belongings. The transportation officer from the county facility from which the inmates are transferred renders the OUI offenders, their paperwork, and their belongings to the custody of Longwood.

A Longwood correctional officer then proceeds to fill out a "Bookings and Admissions Check List". The residents are issued linens and supplies and sign the "Linen Inventory" upon receiving their goods. A CO then conducts an inventory of the new residents' personal belongings. Unlike the county facilities, or MCI-Framingham, Longwood residents are allowed to keep their belongings in their dormitory style room. Each resident is allowed to keep a maximum of twenty dollars. They are not allowed to keep checks or credit cards, and if they still have

their driver's license, it is confiscated by Longwood security staff and returned to the Registry of Motor Vehicles. Checks, credit cards, and cash in excess of twenty dollars are given to the institutional treasurer and the resident is given a receipt.

The residents are given a copy of the "House Rules and Regulations" and the "Resident Orientation Manual" and asked to read them both thoroughly to familiarize themselves with the DOC policies at the Longwood Treatment Center. Before residents are brought to their assigned room, identifying photographs are taken and a strip search is conducted by security personnel. As soon as the institutional physician or physician's assistant is available, the new resident will be given a complete physical. The physician or physician's assistant is scheduled to maintain regular hours at Longwood five days per week.

The new residents meet with both the Deputy Superintendent (DS) and the Assistant Deputy Superintendent (ADS). The ADS reviews the rules and regulations with each new Longwood resident and explains the various policies each resident is expected to follow. The ADS details such policies as "wake-up" time (7 am), hours that the charge phone may be used (7am-10:30pm), the major counts (seven throughout the day at which time all residents must return to their rooms), yard hours (Noon-1:30pm; 5pm-dusk), nap times (Noon-1:30pm), and lights out (11pm).

The ADS informs new residents that on their first day at Longwood, anyone can visit them and bring them clothing, books, and/or other things the residents would like to have while they are at Longwood, subject to the provisions contained in the rules and regulations.

The ADS explains to the new residents that they will have two counselors, a Valle Associates counselor for alcohol treatment, and a DOC counselor for any legal or departmental issues which may arise. The ADS also tells the new residents that Longwood is a unique facility, and will be a much different experience than

that at the house of correction or MCI-Framingham. The ADS emphasizes that the primary focus at Longwood is treatment, and that if a person does not want to participate fully in the program, the Longwood Administration will send that person back to higher custody. The ADS further points out that each resident is highly trusted at Longwood, and explains that there are no walls or bars, and that downtown Boston is a short MBTA ride away. The ADS lets the residents know that if they decide to walk out the door, they will be charged with escape, returned to higher custody, and faced with an additional sentence.

The ADS tells the residents that as long as they follow the rules and regulations and actively participate in the treatment component, they will have no problems during their stay at Longwood. The ADS also tells the residents that he is available should any questions arise regarding the rules and regulations.

All new residents are then given a tour of the facility, and the rules and regulations are further explained to them. They are shown what areas are restricted, what halls and stairs are to be used, and the proper procedures to follow should they wish to speak to a counselor (i.e., obtaining a hall pass), and any other procedures to which they must adhere.

The DS then speaks with each new resident about the history of Longwood, what is expected of participants, and how the particular treatment at Longwood has successfully helped past participants with their alcohol abuse. The DS discusses the resident's familial history, and tries to make new residents feel comfortable in their new environment. The DS emphasizes the fact that Longwood is coeducational, and that it is a minimum to pre-release security facility. The new resident is told that if anyone attempts to escape, the person will be subject to the stiffest penalty under the law. The DS tells the resident that compared to county facilities and MCI-Framingham, Longwood is not hard time, but rather a treatment program, and points out that there should be no reason for a participant

to even contemplate escaping.

The DS concludes the orientation by emphasizing that the Longwood program is "constructive, programmatic treatment", and that the program will work if the individual allows it to work. The DS also explains that the program is available to people who want help, and that those who do not participate will be sent back to the facility from which they came. The DS addresses any questions the new resident might have up to this time.

Following the meeting with the Deputy Superintendent, each new resident meets with the Director of Treatment (DOT). The DOT and the resident discuss the treatment component of the program, the DOT preparing the residents for what they can expect in terms of treatment.

The new residents then meet with their assigned DOC counselor and an intake evaluation is completed. The DOC counselor gathers information to be used at the Initial Classification Hearing, becomes better aquainted with the new resident, and helps to address any issues or apprehensions the new residents may have.

B. Valle Orientation

New residents are placed into an Orientation group conducted by a Valle counselor. The group meets Monday through Thursday afternoons and Friday mornings, and all new residents are required to attend. Here the resident completes several tests, including the Minnesota Multiphasic Personality Inventory (MMPI), MacAndrew Alcoholism Scale, Michigan Alcohol Screening Test, and Alcohol Use Inventory.

The Valle Orientation counselor explains the purpose of the evaluative testing and discusses how it will help the staff become more familiar with an individual's alcohol abuse, and how it will help both the new resident and the Valle counselor

design a treatment plan for the individual to follow.

Specifically, the MMPI consists of 556 true/false items which yield 14 scores designed to measure an individual's personality, including commonly used defense mechanisms, ways of relating to the world, psychopathology, socialization, and somatic complaints. The test also reflects the individual's current emotions and intensity, such as depression, anxiety, and hostility. Among the personality characteristics the test measures are hypochondriasis, depression, hysteria, masculinity/femininity, paranoia, and introversion. Four scales are utilized to assess the validity of the test taken by the individual. These scales check on carelessness, misunderstanding, and test taking attitudes. For example, they detect test taker's attempts at deliberately trying to trick the tests by randomly answering the questions or responding in a way indicative of pathology, confusion, resistance, or exaggeration of difficulties. Residents whose test scores reflect such aberrations retake the test.

In addition to the standardized MMPI calculations, Valle Associates provides access to 100 special scales that provide additional information useful for treatment planning. For example, one scale reflects the client's willingness (or lack of) to be open and self-disclosing, as well as the amount of denial the person exhibits, and another scale provides information for treatment planning on a client's impulsivity and potential ability to maintain sobriety without external controls.

The MacAndrew Alcoholism Scale, a subscale of the MMPI, is used to differentiate alcoholics from non-alcoholics, and consists of 49 True/False items which measure long term character traits which indicate addiction proneness and compulsivity.

The Michigan Alcohol Screening Test (MAST) consists of 25 items which calculate the client's pattern of alcohol use, drinking history, and the impact of

drinking on the person.

The Alcohol Use Inventory (AUI) is comprised of 147 items which require a "yes" or "no" response. Multiple factors of drinking are measured through three domains of the database - drinking symptoms, drinking behavior, and drinking benefits. The inventory is based on the belief that alcoholism is a complex syndrome which requires differential treatment. The inventory provides information about the client's perceived benefits of drinking, drinking style, symptoms of a drinking problem, negative consequences of drinking, and acknowledgement of a drinking problem.

A structured questionnaire which gathers extensive demographic information is also administered to each individual resident. The questionnaire gathers data on the client's first use of alcohol, drinking patterns, and recognition of needed changes to be made in relation to alcohol use. The information is compared to data gathered from the AUI, MacAndrew Scale, and MAST to identify any discrepencies in information.

Finally, clients complete Valle information forms. These include client activity lists, psychosocial client self-reports, emotional behavioral history forms, spiritual history reports, leisure skills history reports, and a drug history and current use inventory.

In total, the results from all of the above tests and inventories enable Valle counselors to design a treatment plan for each individual client. Soon after the results are calculated and returned to Longwood from the Valle Associates office in Lynn, MA, the resident meets with an assigned Phase I counselor to discuss the scores and implications of them for treatment at Longwood.

1. Orientation Group

Once new residents have completed the testing, they commence participation in the orientation group. The purpose of the group and what residents can expect from the treatment component at Longwood, are further explained to them. The resident is informed that orientation typically lasts from seven to ten days. The counselor explains that there are three elements of the treatment plan at Longwood that, if their individual sentences structures permit, each resident will participate in: Orientation and Phase I, Phase II, and Phase III. The counselor then discusses the differences between the roles of the DOC and Valle counselors. New residents are told that although the DOC and Valle work together, many of their daily tasks are different.

Residents are told that DOC counselors are charged with the responsibility of helping residents focus on treatment. In other words, if a resident is particularly occupied with his or her parole date or pending court appearance, and that is somehow impacting on the person's treatment, the resident's DOC counselor attempts to redirect the resident's attention toward treatment. In this way, the DOC counselors contribute to the individual's therapy at Longwood. Their primary responsibilities, however, concern correctional and case management duties (ie. furlough processing, work-release coordination, etc.).

The orientation counselor explains that Valle counselors specialize in the treatment of alcoholism at Longwood by focusing on the attitudes and past drinking and driving behaviors of the resident. During orientation, residents will be introduced to the rules of a group setting, begin developing listening skills, and participate in general discussion sessions focused around the topic of drunk driving. The counselor explains that before leaving orientation, all residents will be assigned a Valle Phase I counselor and placed in a Phase I A, B, or C group . The

counselor explains that Phase I will focus on educating residents about alcohol and alcoholism, Phase II will focus more on individuals' relationships with alcohol in their lives and how it has affected work, friendships, marriages etc., and Phase III is designed to prepare residents for reentry into society through community and work-release programs and outside AA networking. Finally, they are told that the purpose of orientation is to create trust and provide an atmosphere whereby residents can begin examining their own drunk driving and alcoholic behaviors.

The orientation groups, a component of Phase I, are structured similarly to Phase I group therapy sessions to prepare residents for their forthcoming involvement in Phase I. According to Valle staff, the orientation group provides new residents with the framework within which to begin the process of education and group therapy. Therefore, establishing trust at this initial juncture is essential. For many residents, this is the first time they will openly confront their use and/or abuse of alcohol and, as many of them have not participated in a residential treatment program before, the orientation group serves as an introduction to the daily structured setting at Longwood, and ensures that what transpires is confidential information. Since Valle maintains that the fundamental determinant of resident success at Longwood is participation in group sessions, the importance of orientation as a precursor to group therapy is great.

During the first orientation group meeting, the procedural rules of the group are outlined. The counselor explains that the rules are designed to create a safe and productive setting in which the resident can learn about themselves and alcoholism. Confidentiality, initiative, genuineness, the ability to speak in a group, concreteness, speaking for oneself, and active listening skills are stressed in these first orientation meetings. The operational rules are also discussed; for example, there is no smoking, no eating in groups, and no leaving once the group starts.

The precise format of a typical session varies. At times the orientation

counselor will open the session with an exercise. For example, the counselor might ask the residents to write about some positive and negative aspects of alcohol. Once completed, the counselor might ask a resident to relate to the group what they have written. From there, ideally, a discussion about alcohol is generated.

On other days, the counselor may ask one member of the group to tell the group their own story of how they arrived at Longwood, or what events precipitated the person's most recent arrest for driving drunk. Each new client will eventually share their offense history with the group for the purpose of personalizing their drunk driving predicaments and establishing trust amongst fellow residents.

2. Transition Guides

Transition Guides (TGs) were recently introduced to the orientation component at Longwood. TGs are Phase III residents who visit orientation groups on Monday and Wednesday afternoons to answer new residents' questions about treatment, the DOC, and the rules and regulations at Longwood in general. New residents learn from experienced residents what to expect from their stays at Longwood.

The Phase III TGs and the Orientation counselor usually meet once per week to discuss issues of aligning guides with residents, and the importance of encouraging new residents to develop positive attitudes about such things as the limitations of the physical environment at Longwood, the advantages of personal interactions with other residents (informally and formally in groups), and attitudes toward the DOC and Valle staffs. With staff input, TGs stress to new residents that success at Longwood is dependent upon positive attitudes.

Transition Guides make themselves available to all new residents, attracting

them with offers of "straight" information about what it is "really like" in the program. The Orientation counselor maintains that their support has been excellent, and feedback from residents and TGs themselves suggest that the newer residents feel more comfortable talking with a peer about their apprehensions or uncertainties concerning what lies ahead of them.

C. Initial Classification Boards

After meeting with their assigned Valle and DOC counselor and completing Orientation, each resident appears before an Initial Classification Board (ICB). Boards are held at Longwood every Friday. Residents' hearings take place within the first two weeks of their stay at the facility. According to the DOC staff at Longwood, it is expected that by the end of two weeks, residents will have become acquainted with the treatment component of the program, and adjusted to being at Longwood. In addition, this time also affords the counselors, both DOC and Valle, the opportunity to meet with the new resident to gain insight into the individual's history and past experiences with alcohol abuse.

Per DOC policy, the ICB is comprised of five members: the Director of Treatment or the DOT's designee; the resident's Valle counselor; DOC counselor; a security staff person; and, a designated Board Chairperson, usually another DOC counselor. Although security staff was represented at the ICBs one researcher observed, security staff were not included on any of the Boards another researcher observed. The Boards then consisted of only the DOT's designee, who acted as the Chair, and the resident's Valle and DOC counselor.

The purpose of the board hearings are to set goals for each resident. Based on the recommendations made by the resident's DOC and Valle counselor, the resident is offered the opportunity to sign a Classification and Program Agreement

(CAPA) which is a voluntary program offered to some inmates during a classification hearing where the DOC and inmate agree to a scheduled reduction in security according to a standard movement chronology contingent upon positive adjustment and program participation for the duration of the agreement. Inmates who choose not to sign a CAPA are nevertheless designated to participate in certain programs but they are not guaranteed a reduction in security level according to a standard movement chronology.

After the resident is introduced to all the board members, the hearing commences. The resident is asked how things have been going thus far at Longwood, and is invited to ask questions about the program if necesary. The Board Chair asks the resident if they have learned anything about alcohol abuse from the sessions they participated in.

Finally, the resident's assigned Valle Counselor, who has reviewed the resident's test results in a private session and compiled a dossier, informs the Board of the test results and projected treatment needs of the client. In most instances, this is the second time the resident hears of his or her test results. However, if there is no time between the return of the tests and the scheduled ICB, the resident and the Valle counselor will meet after the Board to review the results privately.

Each Valle counselor approaches the task of explaining the results and implications of the tests differently. Some are more technical than others, and others soften the mechanical aspects of the scores and relate their implications for treatment in lay terms. Although the resident is invited to interject with comments or questions at any time, most often they are silent. The Board Chair will ask the resident if they agree or disagree with the result of the tests after the Valle counselor finishes outlining them. Of the fourteen Boards observed by researchers in all but two cases residents agreed with the results.

The DOC counselor is then asked to report on the resident's criminal and treatment history, and if a security person is not present, the DOC counselor relates the housing evaluation reports submitted to the counselor by the security staff in lieu of security's presence. Again, if the Board needs clarification on a particular aspect of the resident's history, the Board Chair will ask the resident to explain. The resident is again asked if they want to contribute, comment or criticize the proceedings or information revealed thus far. If they do not, and if the Board is satisfied that the amount of information generated is sufficient to proceed with making treatment recommendations, then the resident is asked to leave the room while the Board discusses the resident's case.

The Board members ask one another how they feel about the resident. When security is present, that person informs the Board about the participation of the resident in work duties, and contributes other observations concerning the resident's behavior and relationships with others in the unit. The Valle counselor discusses the implications for treatment of some of the issues (ie. criminal and/or alcohol history, reluctance or willingness to participate in class, lack of or strength of family support) that were raised in the hearing while the resident was present. At this point some of the common issues discussed are how much structure and attention a particular individual is predicted to need, whether the resident's length of stay in the program is too short for the resident to receive appropriate attention, and whether there are ancillary needs (ie. medical, mental health) that Valle and the DOC should monitor along with the treatment plan. All Board members participate in this exchange of information and a recommendation is eventually reached.

When the resident is called in to return to the hearing, he/she is informed that while they waited, the Board agreed on recommendations for a treatment plan. Typically, Board recommendations include: 1) the amount of time a resident

will stay in each phase of treatment; 2) activities the resident is mandated to attend; and, 3) projected dates for changes in status from minimum to pre-release. For example, residents are informed that Phase I is typically six weeks, after which they, if successful in Phase I, will advance to Phase II, after which they will become eligible for community restitution, work-release, etc. The Board Chairperson emphasizes that the dates given for advancement from one phase to another are projected, and are dependent upon each resident's demonstrated commitment to treatment.

The resident is asked if he or she has any questions or comments, told that a copy of the Hearing will be sent in writing, and informed that the decision may be appealed to the Superintendent of Longwood in writing within five days. The resident is also told that a Review Board will be held in ninety days, at which time the resident's progress is surveyed, and if necessary, adjustments will be made in the resident's CAPA.

D. The Treatment Component at Longwood

1. Phase I

Phase I of the Valle component at the Longwood Treatment Center is designed to provide comprehensive alcohol education to the residents enrolled in the program. It is an intensive, didactic, psychoeducational process of introducing residents to the disease concept of alcoholism. Residents are informed about the disease of addiction, are introduced to the dynamics of group therapy, and are exposed to the philosophy of Alcoholics Anonymous (AA). A fundamental element of this first treatment phase is helping the residents acquire an understanding of alcohol's cause and effect relationship in their lives, specifically in regard to

driving and public safety, but also in terms of the person's overall life unmanageability due to alcohol. Before moving on to Phase II, the resident is expected to demonstrate an increased understanding of the disease process of chemical dependency, internalize the understanding, utilize a therapy group as a recovery tool, and demonstrate motivation for continuing recovery. Phase I typically lasts six weeks. However, residents who are slower to internalize the psychoeducational experience stay in Phase I longer, and move on according to their individual progress. Similary, those who demonstrate an exceptionally acute grasp of the material move more quickly.

A variety of psychoeducational and therapeutic techniques are used in Phase I in order to reach the goals of sober living. Most of the Phase I activities require mandatory attendance while others, although voluntary, are strongly recommended by the Valle Phase I counselors. Attendance at meditation, lectures, group therapy sessions, AA meetings, discussion groups, and spirituality lectures is required of all Phase I participants. Participation in Twelve-step and Alanon/Alateen meetings is recommended. Mandatory program activities in Phase I are scheduled on a 5 day basis, with the recommended activities scheduled on weekday evenings and weekend days. The full time treatment focus is in keeping with the philosophy of both Valle Associates and the DOC at Longwood-specifically, that alcoholism is a complex, multidimensional illness that requires comprehensive assessment and multi-disciplinary, structured treatment.

The following is a description of each therapeutic technique offered in Phase I. It is based on the accumulation of information from staff interviews, and derived from observations made by researchers as participants.

a) Meditation and Lecture

On Monday through Friday mornings and Tuesday, Wednesday, and Friday afternoons, the Valle staff at Longwood conduct meditation and lecture sessions for Phase I residents. Every resident in Phase I is required to attend both morning and afternoon lectures, and new residents in orientation are also asked to attend the lectures in addition to their own orientation meetings. Attendance is recorded.

The fifteen minute meditation serves as a prelude to the morning lecture. Often it consists of a short reading or prayer taken from AA's "24 hour-a-day" meditation book.

The responsibility for conducting the sessions rotates among the Valle Phase I counseling staff. Similarly, the format of the lecture varies according to who is leading the session. For example, one counselor may give a prepared lecture, another may speak extemporaneously, a third might choose to show a film on alcoholism from Longwood's video education library, and/or a fourth counselor might play a group game designed to educate the resident about alcoholism or an alcohol-related topic. Each week, however, the Valle staff chooses one topic around which the entire week's education will be focused. For instance, weekly themes in Phase I alcohol education at Longwood include "sobriety", "relapse", "recovery", and other issues surrounding those topics such as "coping with anger", "symptoms of sobriety", and "establishing trust".

Discussion in the lecture sessions is limited. Valle counselors expect that the lectures will leave the residents contemplating the issues brought up, in order that later, in their separate therapy groups, the residents will discuss in detail the material covered in the lectures. The Valle staff employ this technique deliberately --the stated philosophy being that it is beneficial for the residents to

assemble on their own or in therapy groups after a meeting to talk over the lecture topics.

b) AA Meetings and A, B, C Groups

On Monday and Tuesday evenings, and Thursday mornings, the Longwood Treatment Center houses AA meetings for all residents. The Valle staff advocate the AA model of mutual help therapy, and incorporate the philosophy into treatment at Longwood. Outside AA groups visit Longwood for the evening meetings, and the Phase I residents conduct their own meetings on Thursday mornings. The Monday and Tuesday evening groups are intended to expose Longwood residents to AA and its availability to them as an outside resource and support network. Members from AA groups across the state visit Longwood at the request of both Valle and DOC staff, share their experiences with the residents, and in some cases, offer to sponsor a resident when he or she is eventually released.

The Thursday morning resident-conducted meetings are similar to the evening AA meetings in that they are "speaker style". Each week, a different Phase I resident is asked to chair the meeting and a panel of four or five other Phase I members join that resident in sharing their experiences with alcohol before the group.

The A, B, C groups succeed either the Monday and Tuesday evening AA or the Alanon groups on Tuesday and Wednesday mornings after the lecture sessions. Membership in these groups is designated randomly. In other words, assignment to an A, B, or C group is decided solely upon the mathematical division of Phase I residents into three groups. Residents remain in the same A, B or C group throughout Phase I. As with the lectures, however, the Valle counselors rotate the

responsibility for leading these discussions. Both instances of rotating staff serve to expose all of the Phase I residents to each of the Valle Phase I counselors. Only in private group therapy sessions are residents assigned one counselor with whom they meet regularly.

In the A, B, C meetings, residents are asked to write their opinions and reactions to the previous evening's AA meeting. They are allowed fifteen minutes. The written work is collected by the counselor, read, and distributed to the particular resident's assigned Phase I counselor who adds it to the resident's information folder. The assignment and the adoption of the information for the resident's file serves many purposes. First, it enables the residents the opportunity to assemble their thoughts, with the writing designed to help them process what they experienced at the meeting the evening before. For the A, B, C counselors, reading the groups' comments introduces them to some of the residents outside of their own assigned therapy groups. For the assigned Phase I counselors, reading through their own group members' comments allows them to monitor each resident's progress and further, the random assignment to an A, B, C group allows the residents themselves to interact in Phase I with other residents outside of their own therapy groups.

Following the brief writing exercise, the residents discuss what they wrote about the meetings. These discussion sessions are relatively open, informal and unstructured, although some counselors follow a specific format. For example, one researcher observed a counselor who, after the writing ended, asked each resident to make a contribution to the discussion. Other group leaders on the other hand, asked for a voluntary exchange of information.

These groups meet each time for 45 minutes, and attendance is required of all Phase I residents assigned to a counselor and an A, B, C section. Unlike the lectures, new residents in orientation do not attend A, B, C groups until they have

actually been assigned to a group and to a Phase I counselor.

c) Group Therapy

Irvin D. Yalom (1970) writes that, "intensive group experience is a powerful agent of change". The Valle staff at Longwood adhere to that philosophy. According to the Valle staff, group therapy at Longwood serves two principle functions. One is pragmatic, the other philosophical. Practically, group therapy is employed as a tool in alcoholism counseling in a Longwood-type setting because it reaches the most number of clients for lower costs. With the use of group therapy, Valle is able to counsel an average of ten residents at one time in a given group meeting. Given budgetary limitations, Valle attempts to provide treatment and education while considering costs.

Philosophically, group therapy in Phase I serves an educational function by providing a forum within which information about the disease of alcoholism is discussed. Further, Phase I groups are designed to assist residents in understanding the role alcohol has previously played in each members' lives and relationships. Phase II will address issues of individual sobriety in more detail.

Valle maintains that Yalom's principles of group psychotherapy (detailed below) operate especially well when counseling alcoholics in groups. Precisely, group therapy encourages a person to be involved with other people. Since isolation and alienation are often synonomous with alcoholism, the group setting enables the recovering group member to begin re-experiencing the world at large via the group. Further, through the group experience, the member also becomes reacquainted (or in some instances acquainted for the first time) with him or herself.

Below are some of the major "mechanisms of change" the treatment staff

accepts as integral components of group therapy at Longwood. The group's goals are:

1. Imparting information -- Phase I groups at Longwood impart factual information about alcohol. Such a didactic focus assists in the breakdown of stereotypes about what constitutes alcohol abuse, and about what "kinds" of people alcoholics are. The acquisition of basic alcohol education assists in the breakdown of denial, and provides a framework for motivated group members to understand the disease and prospective treatment.
2. Universality -- The group experience helps the member realize that he or she is not alone with his or her problems and others share feelings or similar experiences.
3. Instillation of Hope -- Faith in treatment potential, the instillation of hope, and belief in the efficacy of the group are crucial ingredients for a successful group experience. The importance of maintaining hope through group interaction and the therapist's commitment to the group process is vital.
4. Interpersonal learning -- In groups, residents ideally acquire skills to identify the role alcohol has played in each member's life. Particular emphasis is placed on the here and now; the discovery of how one is feeling and how that feeling translates into behaviors.
5. Altruism -- Patients in group therapy are enormously helpful to other members through support, reassurance, suggestion, insight and sharing. Not only are other residents benefited by these therapeutic factors, but patients also receive through the act of giving.

d) The Group Structure

Before moving from orientation, residents are assigned to a Phase I counselor. The caseload of a particular Phase I group leader is a paramount concern when assigning members to groups. At present, there are four Phase I group counselors. In an average six week span, with the center at full capacity, approximately 60 residents are in Phase I. However, clients in Phase I are not simply divided into four groups and assigned to a counselor randomly. Ideally, the Valle staff attempts to match clients who have specific backgrounds, behavioral issues, prior treatment experiences, etc., with counselors who either have expertise in those areas, a special ability to address particular concerns, or a counseling style that is foreseeably complementary to certain resident issues. Since there is inevitably an overlap of people moving in and out of Phase I groups at different paces, consistent adherrence to the above preferred approach to assigning groups is difficult. Taking into account such realities, the Valle staff nevertheless attempt to assign residents to groups with counselors adept in certain areas of knowledge matching a resident's needs and with other residents whose backgrounds and/or treatment needs may be similar.

e) Spirituality Groups

One day per week, Valle conducts spirituality lectures and discussions. Early in the Longwood program, these meetings were called Church and Spirituality groups and a Protestant chaplain visited Longwood to address the group. Attendance was sparse, since the activity was not mandatory. The Valle staff has since changed the premise of the meetings. Presently, one hour is set aside each week for Phase I residents and a Valle counselor to assemble and discuss issues in

spirituality of particular concern to alcoholics in recovery. For example, the reference in AA to a "Higher Power" may be problematic for some residents. That issue might be brought up at a spirituality meeting. These gatherings, although structured similarly to the morning lectures, are less didactic than the lectures. As with the lectures, the Valle counselors rotate the responsibility for leading the spirituality groups. Four counselors per month alternate giving the lecture and the lecture topics variety. The following is an account of a typical meeting observed by one researcher.

> Residents in Phase I gathered in the cafeteria. A Valle counselor entered the room and distributed a handout titled "Humility" to each resident. Beginning at the front of the room, the counselor asked each resident present to read a line of the handout, which was an excerpt from AA's One Day At a Time book. After the residents finished reading, the counselor offered his own interpretation of the passage, and opened the meeting up for discussion. The particular passage stirred much controversy and the exchange that occured, both among residents, and between residents and the counselor, became philosophical. This was apparently the intent. Some residents disagreed vehemently with the tenor of the passage. Others opposed its message, and still others defended it in its entirety. Irrespective of the disparity in viewpoints, the session served as a forum for which individual philosophical differences between residents, and between residents and Valle counselors, were unearthed. Thus, a discussion of spirituality transpired.

f) From Phase I to Phase II

Successful completion of Phase I is determined in numerous ways. As the six week projected movement date (offered to the resident at the Initial Classification Hearing) nears, the resident's Phase I counselor meets with him or her to either congratulate the resident on the successful completion of this first phase and prepare him or her to move to Phase II, or to discuss the reasons why the counselor feels the resident would benefit from further Phase I education. If the resident has

met the terms of the client treatment contract drawn and signed by the resident and the DOC and Valle counselors prior to entering Phase I, then he or she will move on to Phase II. In addition to attending the required programs, residents in Phase I must meet other criteria before transferring into Phase II of the treatment component at Longwood. These criteria are:

1. Demonstrating understanding of the physical, mental and spiritual disease process of chemical dependency.

2. Internalizing the disease process of chemical dependency, which entails admitting to being an alcoholic and trying, at minimum, to accept that fact.

3. Displaying insight into the cause and effect relationship between chemical dependency and life unmanageability -- i.e, that the person's drinking and driving caused this incarceration.

4. Demonstrating ability to effectively use the group process as a recovery tool; and,

5. Displaying motivation for continued recovery which is achieved by attending non-mandatory programs in Phase I, offering assistance to others, demonstrating an overt willingness and desire to attain sobriety.

The Valle counselors measure the attainment of these criteria from information garnered in various ways. The assigned Phase I counselor makes a recommendation that a particular resident advance to Phase II from the knowledge

of the resident's progress in the use of group therapy. The counselor also collects the A, B, C group writing assignments, has knowledge of the resident from lectures, and has occasionally met with the client over the course of the six weeks in one-on-one sessions. The counselors also write weekly progress reports for each client and these are included in the residents' folders. In addition, the assigned Phase I counselor periodically and informally meets with the resident's DOC counselor to discuss a particular issue, and the information generated from these collaborative sessions is useful for assessing a particular resident's readiness to advance.

Just as a resident who is slower to meet the above criteria may move into Phase II after the six week projected date passes, those who testify to reaching such goals earlier may advance sooner. Both those who proceed earlier than their projected date, and those who will advance on their projected date meet with their assigned counselor a few days before they are moved to discuss their performance in Phase I, and prepare for the transition into Phase II. The resident and the counselor decide how the resident will terminate the Phase I group experience, and talk over any apprehensions the resident has about moving on to Phase II.

Those who will surpass their projected date also meet with their Valle counselor to discuss in detail why the counselor feels a move at that time would be premature. There the resident and counselor deliberate over the issues that are keeping the resident from advancing, and talk over how the resident could apply themselves differently to capitalize on the education offered in Phase I.

When a resident is deemed ready to move into Phase II, the individual's name and information is given to the Phase II therapists, and preparation for the resident's participation in Phase II gets under way.

2. Phase II

Phase II of the Valle treatment component at Longwood focuses more on actual therapy than does Phase I, which is more educational. Where Phase I is designed to educate the residents about alcohol and its effects on their lives, Phase II is designed to help the residents internalize the education, and begin to examine individual issues around the resident's own life unmanageability due to alcohol comsumption. As one Valle counselor stated "Phase I opens the resident up to alcoholism education. By the time they get to Phase II, the residents are "open sores" and the healing process begins."

When the residents reach Phase II after meeting the criteria for leaving Phase I, they meet with a second assigned counselor to discuss an initial treatment plan. There the client and counselor review in detail a list of fifteen criteria to be met by the client before being eligible to advance to Phase III. In addition to the five criteria to be met for the successful completion of Phase I (which residents must again exhibit to complete Phase II) residents in Phase II need to demonstrate:

- effective communication skills
- the ability to identify and share unmanageable life situations with others
- the internalization of acceptance and the utilization of Steps One, Two and Three in the AA program as a mode of integration, of accountability, and responsibility for behavior patterns
- an understanding of abstinence and need for continuing treatment (AA, NA, etc.) in order to continue behavior change
- an understanding of the process of relapse, ability to identify personal warning signs, and ability to use personal relapse intervention skills
- the ability to cope with situational stress through applying relaxation techniques, meditation and physical recreation

- an understanding of passive, aggressive and assertive behaviors associated with cause and effect relationships
- the ability to use personalized alternatives to chemical dependency and abuse
- an understanding of how alcoholism/drug abuse has interfered with and/or affected relationships with family and significant others
- skills toward personal growth, improved health, positive attitudes and increased awareness of self and social responsibilities.

At the time of this research, residents in Phase II participated in one lecture and one group therapy session per day, Tuesday through Thursday. On Friday, Phase II residents meet together in the lecture room in lieu of their group therapy sessions to discuss the week's issues together with both Phase II counselors and the Phase II Senior Counselor. In addition, as in Phase I, Phase II residents organize and conduct their own "speaker-type" AA meeting which are also held on Friday mornings.

The morning Phase II lectures are more participatory than those of Phase I. As in Phase I, the lecture is prefaced with a short meditation. The lectures focus on a topic of the week. For example, in two weeks of participant observation, the topic's recovery and communication were discussed. In one lecture section, a Phase II counselor first discussed important components of good communication skills, (i.e. active listening skills), then suggested that the group play a game. Per the counselors direction, the residents paired up, with one resident acting as a listener, the other describing their best friend. Following the exercise, the residents regrouped and discussed the activity and how it helped them to understand the importance of good communication skills. The counselor explained that the lack of effective communication skills may have played a part in the

resident's history of difficulty in various relationships, which may have in turn contributed to various drinking behaviors.

Another lecture topic focused specifically on the pressure on residents to drink. The counselor delineated suggested steps each resident should follow if faced with a situation on the outside where such pressure was evident. The group as a whole discussed the steps, and residents offered their own suggestions for avoiding the urge to drink. The homework assignment for that evening asked residents to consider a hypothetical situation, namely: What would they do if on the outside, they were faced with a certain situation which included drugs or alcohol? The assignment was collected the next day. As in the Phase I A, B, C group fifteen minute writing exercises, the homework assignments are designed to encourage the residents to think about and process the information put forth in the lectures, and in addition, it is hoped that the residents will discuss the assignment with other residents outside of the lecture.

a) **Phase II Groups**

Generally, the groups in Phase II adhere to the topics being discussed in a particular week and, if the group discussion transgresses the desired topic, Phase II groups at least begin by recapitulating some of the issues brought out in the morning lecture. After petitioning Phase II residents for their approval, a DOC researcher was granted permission to participate in two weeks of Phase II group therapy sessions at Longwood. Due to the confidentiality of the groups, none of what actually transpired will be discussed here. However, there are at least five general goals of Phase II group therapy at Longwood. These are:

1. Responsibility for focusing on sobriety as the ultimate goal of treatment;
2. Recognition and identification of behavioral patterns of alcoholics;

3. Development of relapse prevention strategies;
4. Discussion of life after drugs; and,
5. Continual focus on increasing the self esteem of alcoholics in recovery.

The rationale for these uses of this type of treatment in Phase II is that:

1. it is economical;
2. the therapist sees how the client relates with others;
3. the group encourages interdependence on peers rather than the potentially highly charged dependence on a therapist;
4. the client has the opportunity to play out and then discover alternatives to the role or roles played in their family of origin (especially important for adult children of alcoholics and those from other dysfunctional families);
5. group therapy counteracts isolation that is characteristic of alcoholics; and,
6. within the group, an environment of safety as well as structure is provided.

The principles of group therapy, such as those of Yalom's defined earlier in this section, are utilized to a greater extent in Phase II groups. Whereas imparting information about alcoholism is a primary objective of the Phase I groups, Phase II therapy concentrates more on feelings and on providing residents with the tools to continue and maintain a desire for sobriety.

b) Women's Group

On Monday afternoons, the women from both the Phase I and Phase II sections meet in a special group. Topics vary, and because of the confidentiality of such meetings, researchers were not allowed to participate. Instead, the Phase II Senior Counselor explained the group to the research team. In general, the focus of the women's groups at Longwood is on what it is like to be an alcoholic woman experiencing incarceration. Relationships with men, feelings about motherhood and sexuality, and issues in women's health are common topics discussed by the women in these groups. According to the Phase II therapists, the group enables the women the opportunity to talk with other women, to perhaps be more self disclosing than in the larger groups, which are disproportionately comprised of men. The groups afford the women privacy and space whereby which they can ideally feel more free to express themselves.

3. Phase III

a) Community Restitution/Work Release

After a resident successfully completes Phase II of the treatment component, he or she becomes eligible for Phase III. The first component of this phase requires that each resident obtain an outside AA sponsor, establish an outside AA network by attending three AA meetings per week, and commence participation in the Community Restitution Program (CRP), a program which enables residents to work outside in neighboring areas in cleanup or horticultural projects. In this phase, although residents are scheduled to continue to participate in treatment by attending CRP meetings, the emphasis is on building an outside support system to

assist the resident in the transition from incarceration to society as a recovering alcoholic.

Once residents have met the CRP requirements, which include continuing to demonstrate incentive and motivation for recovery, they become eligible for work-release. Once approved for work release by the Review Board and Superintendent of the facility, the resident is allowed to seek outside employment. If the resident does not have a job to return to, or if the commute to their previously held position is too far from Longwood for them to commute to, the resident can utilize the resources of the Boston Employment Resource Center (BERC) to help secure employment.

A DOC counselor coordinates the work-release program. The coordinator meets with each resident approved for work-release to issue a temporary community release pass in order that the resident can leave Longwood to seek employment, and explains the policies and procedures of the work-release program to each resident. After the residents find a suitable job, they give all relevant information, including verification of work schedules, job sites, transportation arrangements and contact persons to the work-release coordinator. The work-release coordinator then meets with the prospective employer and together they discuss the conditions of the work-release program which the resident must adhere to while in outside employment.

Residents on work-release cannot be signed out of the institution for more than twelve consecutive hours. In accordance with M.G.L. C.30, C.30A, and C.37, fifteen percent of the resident's gross pay is taken by the state for room and board. Twenty-five percent of the net pay is placed into a savings account payable to the resident upon release, and the remaining money is placed into the individual's institutional account. While participating in the work-release program, a resident is allowed to keep fifty dollars to help defray the cost of transportation and meals

purchased outside of the institution while at work. Both telephone and on-site spot checks are conducted by the work-release coordinator and/or security staff to ensure that the resident is abiding by the conditions of the work-release program, and showing up at work.

At all times a resident is outside of the institution he/she must carry either a temporary community release pass or a permanent community release pass.

b) Community Restitution/Work Release Groups

Upon completing Phase II and becoming eligible for Community Restitution, residents essentially discontinue participation in structured treatment. There are, however, Valle conducted Community Restitution and Work-Release meetings that residents in this status of the program continue to participate in.

According to the Valle staff, the purpose of the community restitution and work release meetings is to "touch base" with residents to discuss issues around resident adjustment to being outside of the facility. Both the work release and community restitution groups are relatively unstructured and informal, but are set up similarly to Phase I and II groups.

Both community restitution and work-release groups discuss how the resident is feeling about treatment and work-release groups specifically process information relating to the resident's recovery and involvement in AA. Valle counselors rotate the responsibility for monitoring these groups once per week on Saturday.

c) Program Related Activities

Program related activities (PRAs) are part of the Phase III component of the Longwood program. The PRA is a structured program of release which supports

and complements the treatment component of the Longwood program. PRAs are used by residents to attend outside AA meetings, help residents to build support networks, and to begin reintegrating into the community.

The majority of PRAs are used for therapeutic purposes such as attending AA meetings and participating in further alcohol treatment, but PRAs may also be used for other authorized activities. Other authorized activities include health services, legal services, religious services, recreational activities and educational programs. In addition, PRAs are sometimes used for residents who want to go shopping, attend a movie or a ballgame. Such activities require an approved sponsor.

The resident requesting a PRA must first be approved for pre-release status. If the resident has pre-release status and is therefore eligible for a PRA, they complete a PRA community release permit and submit it to their DOC counselor. The DOC counselor explains that there are restrictions which the resident must respect while on a PRA release. Specifically, the resident must attend the program specified on their application at the exact time cited. The DOC counselor reviews the application, and if they deem the PRA appropriate, approve it. Another DOC counselor who serves as the PRA coordinator, the Deputy Superintendent, and the Superintendent ultimately approve or reject the PRA application.

d) Furloughs

Furloughs are used at Longwood to complement treatment and to assist residents in community reintegration. At Longwood, residents are eligible for furloughs after participating thirty days in treatment. If interested in obtaining a furlough, eligible residents submit an application to their DOC counselor. Along

with the application, residents are required to submit an itinerary citing where they plan to spend their furlough, the times they will be where cited, and a telephone number at which they can be reached. The resident's DOC counselor compiles a progress review of the furlough applicant, and along with the completed application and itinerary, submits the information to the furlough coordinator. The furlough coordinator, another DOC counselor, reviews each resident's petition for a furlough, and presents the information to the Furlough Board. Furlough Boards are held at Longwood once per week. The Board is comprised of the Director of Treatment (DOT) who acts as the Board Chair, a security staff person, the resident's DOC counselor, and the furlough coordinator. The Board reviews each resident's application, obtains verification from the DOC counselor concerning the resident's itinerary and discusses both the resident's participation in treatment and their behavior and attitude in the program thus far. The resident is not present at these hearings.

After the meeting, each resident who requests a furlough is notified of the Board's decision. Initial furloughs, which are twelve hours, require the final approval of the DOC Commissioner of Correction. Subsequent twenty-four hour furloughs are ultimately approved by the Longwood Superintendent. Once the furlough is approved, the police in the town in which the resident will take their furlough is notified.

E. The Aftercare Component

1. Exit Interviews

Prior to being released from the Longwood Treatment Center, residents meet with the Director of Treatment (DOT) or the DOT's designee for an exit

interview. These interviews in no way affect the resident's eligibility for release. Rather, they serve as an informal means by which the Longwood staff gain a sense of the resident's assessment of the program. The residents are asked whether or not they liked the program and what kind of help, if any, they received from participating in the program. The DOT (or designee) asks the resident where they will be living and what type of employment they will undertake once released. The DOT (or designee) also verifies that the resident has completed an aftercare contract.

The residents complete a program evaluation and discuss their opinion of the program with the DOT (or designee). Residents are also asked if they will come back to Longwood and participate in such activities as Family and Friends of Longwood. The resident is encouraged to come back to visit and is asked to sign a visitation request.

2. Contact With the Aftercare Coordinator

According to both the DOC and Valle at Longwood, the most important segment of the aftercare component at Longwood is the released individual's commitment to maintaining contact with the Longwood staff through the DOC aftercare coordinator. The aftercare program was initiated for purposes of: 1) compiling statistics on the post-Longwood activity of released residents to determine rates of recidivism and therefore obtain indications of program effectiveness; and, 2) assisting residents in community reintegration by acting as a referral source in areas of alcohol treatment or employment.

Before being released from Longwood, each resident is required to complete and sign an aftercare contract. Each resident meets briefly with his or her Valle counselor and DOC counselor to discuss post-Longwood intentions regarding

attendance at AA meetings, pursuance of further alcohol counseling, employment plans and intentions regarding future contact with the Longwood aftercare coordinator. In addition, the contract lists the behavior changes the resident intends to implement after release. The resident, the DOC counselor, and a Valle aftercare counselor sign and date the contract. Residents admitted to the program under the revised screening procedures, in addition to completing the above contract, have already signed a form committing themselves to meeting the terms of the aftercare contract and are aware that if they do not meet the conditions stipulated in the document, their parole/probation officer, if applicable, will be notified.

The prior-to-release meetings between the residents and their DOC counselor and Valle counselor are short. The Valle counselor responsible for aftercare at Longwood under the present treatment plan commented that an aftercare plan is essentially being formulated throughout the various phases of treatment at Longwood, and it should be implicitly understood throughout the program that the terms of the contract are basically the personal goals each of the residents have been setting for themselves throughout the program.

Per the terms of the signed aftercare contract, each resident agrees to participate in both phone and personal interviews with the DOC aftercare coordinator. Before a full-time aftercare coordinator was hired in October, 1985 a DOC research intern assisted in the implementation of the aftercare program by conducting telephone interviews with released residents. Before long, the task proved cumbersome for one part-time person and the aftercare initiative was restructured.

In October 1985, the newly hired aftercare coordinator formulated an interview schedule. In the original proposal, the aftercare coordinator intended to conduct two telephone interviews with each released resident two times per month

for two years after a resident's release and once every three months after the two year period, and one personal interview every three months for the first two years after a client's discharge.

By the end of October 1985, over eighty residents had been released from Longwood, and achieving the above goal proved impossible. Instead, the coordinator concentrated his efforts first on conducting one telephone and one personal interview with all released residents and second, if time permitted, he then attempted follow-up phone interviews.

Per the request of the research team, the aftercare coordinator submitted the following information which describes the aim of the phone and personal interviews, and outlines some of the problem areas in the aftercare objective at Longwood.

3. Telephone Interviews

The telephone inquiry consists of a series of questions primarily pertaining to an individual's drinking behavior after release from Longwood. For example, the coordinator asks released residents if they have been drinking, and if so, what was their longest period of sobriety. Individuals are told that the information is used mainly for statistical purposes and are thus encouraged to be candid in their responses. The coordinator asks releasees if they have been attending AA, how often, if they have attended any other type of outpatient counseling, if the former resident is employed, and finally, if, in retrospect, the graduate feels the Longwood program was beneficial and if the resident will return to participate in the Friends of Longwood program.

Following the telephone interview, the former residents are thanked and reminded that the aftercare coordinator will notify them in two months to schedule

a personal interview. The aftercare coordinator records the responses to the telephone interview in each resident's aftercare file, and if he judges it necessary, informs the former resident's parole or probation officer (where applicable) of any serious violation in the person's parole or probation conditions.

4. Friends of Longwood

Friends of Longwood is a monthly alumni program run by the aftercare coordinator and one Valle counselor. Former Longwood residents are invited to attend these gatherings, which consist of breakfast, an introduction by the Superintendent of the Treatment Center, comments and an update on events by the aftercare coordinator, and a presentation by an invited guest speaker. After the presentations are completed, the graduates are invited to openly share with the group their experiences since being released from Longwood. Many current Longwood residents attend the Friends of Longwood meetings, although attendance is not compulsory. The meetings conclude with a distribution of sobriety coins and "Friends of Longwood" membership cards to the returning graduates who have attained and maintained sobriety for 3, 6, 9, and 12 months.

Following the Friends of Longwood meetings, a small group of graduates and soon-to-be-released residents congregate for a prior-to-release meeting where the graduates help prepare the soon-to-be-released residents by informing them of what to expect after release. For example, the prior-to-release committee members discuss with the residents such things as difficulties in dealing with peer pressure after release, and the importance of attending AA and obtaining an AA sponsor. At most meetings, according to the aftercare coordinator, there is considerable discussion between the graduated and graduating residents. The residents about to leave Longwood claim that these meetings help them to prepare

for a positive reintegration into society.

5. Personal Interviews

The personal interview is conducted either at the former resident's home or at a neutral meeting place. Upon meeting, graduates are handed a copy of their aftercare contract to review and assess the extent to which they are complying with its terms. The aftercare coordinator then reminds the graduates that the primary purpose of the interview is to gather statistics. The coordinator again asks if the graduates have been drinking since their release from Longwood, if they have been rearrested, if they attend AA, and if they are employed. During the personal interview, the aftercare coordinator asks questions pertaining to their level of family support, if any members of their family are alcoholics, and if they're involved in any alcoholism counseling. The interview concludes with the coordinator asking the graduates specifically if and how the Longwood program benefitted them. Upon completing the interview, the aftercare coordinator evaluates the clients in terms of their personal appearance and general attitude, and assesses the graduate's physical surroundings and level of family support. For each category, the coordinator rates the clients on a scale of one (poor adjustment) to ten (exceptional adjustment), summarizes the interview in a narrative, and files it in the client's aftercare folder. Again, the aftercare coordinator notifies the graduate's parole or probation officer if he judges that the graduate has seriously violated the terms of their parole or probation.

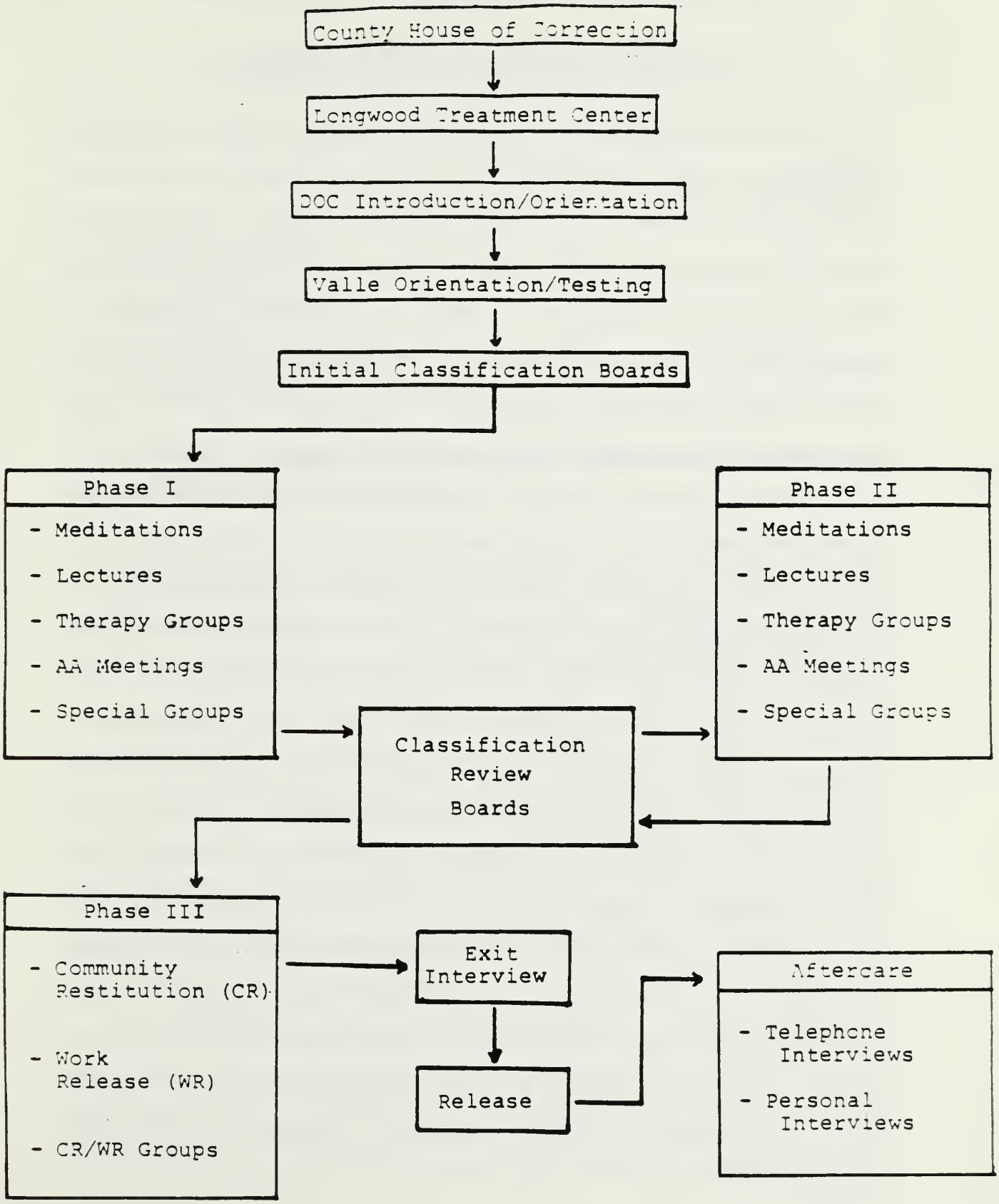
F. Chapter Summary

The above chapter describes the movement Longwood residents typically

encounter from admission to release from the treatment center. To summarize briefly, each new resident, upon admission, meets with the DOC administrative staff at Longwood, as well as with an assigned DOC counselor. At these meetings, residents are introduced to the regulations and policies of the institution, and briefed on the treatment aspect of the facility. All new residents commence participation in a Valle conducted orientation session. There they complete a battery of tests, the results of which are used to design a treatment plan for the individual resident to follow. In addition, residents in orientation are introduced to a group setting similar to that which they will participate in during Phase I and II. All residents appear before an Initial Classification Board where test results are discussed and goals are set for each resident.

Phase I of the treatment program introduces residents to the disease concept of alcoholism by utilizing meditations, lectures, group therapy, spirituality groups and AA meetings to achieve the goals of education. Whereas Phase I is educational, Phase II of the treatment component is more therapeutic. Individuals in Phase II are expected to examine their own individual behaviors in relation to alcohol more closely. Here residents must exhibit characteristics such as an ability to share unmanageable life situations with others, the internalization of Steps One, Two and Three of AA, and a developed ability to locate alternatives to alcohol and other drugs.

Finally, Phase III of the treatment component seeks to reintroduce residents to the community through a variety of program offerings such as community restitution, work-release and furlough activities. The aftercare component, comprised of telephone and personal interviews with graduates, was designed for the purpose of collecting statistics on the post Longwood adjustment of graduates, as well as to assist them by acting as a referral source. All residents participate in aftercare as a condition for acceptance into the Longwood program.


County House of Correction
Longwood Treatment Center
DOC Introduction/Orientation
Valle Orientation/Testing
Initial Classification Boards
Phase I
- Meditations
- Lectures
- Therapy Groups
- AA Meetings
- Special Groups
Phase II
- Meditations
- Lectures
- Therapy Groups
- AA Meetings
- Special Groups
Classification Review Boards
Phase III
- Community Restitution (CR)
- Work Release (WR)
- CR/WR Groups
Exit Interview
Release
Aftercare
- Telephone Interviews
- Personal Interviews

VII. OUTCOME MEASURES OF PROGRAM EFFECTIVENESS

This section examines the impact of the Longwood program on program completers' post-release adjustment. While the concept of post-release adjustment can be variously defined, five outcome measures of program impact will be examined: 1) the number of individuals who were arrested for OUI and non-OUI offenses at least once subsequent to release from Longwood; 2) the number of individuals who were returned to prison within one year of release from Longwood; 3) the post-release self-reported drinking behavior of Longwood releasees; 4) post-release participation in alcohol counseling; and, 5) post-release employment status.

The following section examines the post-release adjustment of all Longwood residents released from the treatment center from April 10, 1985 through June 30, 1986. In total, three hundred and five (305) residents were released during the period under consideration (see Table VII.1). However, forty-two of those releasees constituted program failures and were excluded from the follow-up study, thus reducing the total follow-up population to two hundred and sixty-three program completers. Program failures are those Longwood residents who either escaped from the treatment center during the period under consideration, or were returned to their sending institution for a disciplinary infraction before completing their term at Longwood. In total, there were 38 returns to higher custody, and 4 escapes. Of the remaining two hundred and sixty-three (263) program completers, one hundred and ninety-three (193) were released from Longwood on a good conduct discharge (GCD) at the completion of their sentence, sixty-four (64) were paroled from the institution, five (5) were granted a court release on a revised and/or revoked sentence, and one (1) completed his sentence at Lemuel Shattuck Hospital.

Table VII.1

Program Completion Status of Individuals
Released from Longwood, April 10, 1985 - June 30, 86

	Number	Percent
Program Completers	263	86
Program Failures	42	14
Total Follow-up Population	305	100

A. Number of Program Completers Arrested Subsequent to Release from Longwood

Program completers released from Longwood between 4/10/85 and 6/30/86 were followed-up at three, nine, and twelve months after release. Because the release dates for the sample of 263 program completers varied, fewer program completers were available for follow-up at the nine month and twelve month follow-ups than were available for the six month follow-up. Specifically, 263 or the entire population released from 4/10/85 to 6/30/86 were included in the six month follow-up; 174 or 66% of the 263 program completers were released from 4/10/85 to 3/31/86 and were able to be included in a nine month follow-up; and, 99 or 38% of the 263 program completers released from 4/10/85 to 12/31/85 were able to be included in a twelve month follow-up.

Court records and warrant checks were conducted on program completers for each of the three follow-up periods. Both the court record checks and the warrant checks revealed the number of times each releasee was arrested during the period under consideraton. Table VII.2 indicates the number of releasees with no

subsequent arrests, releasees with at least one subsequent arrest for OUI, and releasees with at least one subsequent arrest for non-OUI offenses, at the six, nine, and twelve month follow-up periods. It was not possible to determine from the court records and warrant checks, however, the number of arrests for non-OUI offenses which were in fact alcohol-related (i.e., disorderly person).

As can be seen from Table VII.2, at the six month follow-up, 86% (226) of the 263 program completers were arrest-free for six months after release, 4% (11) had at least one subsequent arrest for OUI, and 10% (26) had at least one subsequent arrest for a non-OUI offense. Of the 174 program completers available for study at the 9 month follow-up, 70% (123) were arrest-free nine months after release, 13% (22) had at least one subsequent arrest for OUI, and 17% (29) had at least one subsequent arrest for a non-OUI offense. At the 12 month follow-up, 69% (68) of the 99 program completers were arrest-free for 12 months after release, 11% (11) had at least one subsequent arrest for OUI, and 20% (20) had at least one subsequent arrest for a non-OUI offense.

Table VII.2

Rearrest Status/Offense Type for Residents Released From Longwood At Six, Nine, and Twelve Months After Release

Rearrest Status/ Offense Type	Follow-up Period 6 Months N	%	9 Months N	%	12 Months N	%
Releasees with no subsequent arrest after release	226	(86)	123	(70)	68	(69)
Releasees with at least one subsequent arrest for OUI after release	11	(4)	22	(13)	11	(11)
Releasees with at least one subsequent arrest for non-OUI offense after release	26	(10)	29	(17)	20	(20)
Total	263	(100)	174	(100)	99	(100)

B. Number of Releasees Recommitted to Prison Within One Year of Release

A recidivist is defined as any individual who was reincarcerated for more than 30 days within a year following release from Longwood. To measure the rate of recidivism for the Longwood Treatment Center, the ninety-nine program completers who were released for one year were tracked for one year to determine how many were returned to prison for more than 30 days within that time.

As was indicated in the previous section, 31% (31) of the 99 program completers had at least one subsequent arrest in the year following their release. Specifically, 11% (11) of the 99 had at least one subsequent arrest for OUI after release and 20% (20) had at least one subsequent arrest for a non-OUI offense after release. Table VII.3 displays the type of charges received by the 31 releasees with

an arrest within one year after release. As was previously mentioned, however, it is not possible to determine how many, if any, of the non-OUI offenses were alcohol-related.

As can be seen from Table VII.3, eleven releasees were charged with Operating Under the Influence, five people were charged with a person offense (i.e., assault and battery), five were charged with a property offense (i.e., breaking and entering), three were charged with operating after revocation, one was charged with operating to endanger, one was charged with being a disorderly person, one charge was levied for speeding, and one for fraud. One releasee was charged with a drug offense (possession of a hypodermic needle), one person was charged with non-support, and one charge was unknown.

Table VII.3

Type of Charge Received by Residents Released for One Year

Offense Type	Number	Percent
OUI	11	35
Person	5	16
Property	5	16
Operating After Revocation	3	10
Operating to Endanger	1	3
Disorderly Person	1	3
Speeding	1	3
Fraud	1	3
Drug	1	3
Non-Support	1	3
Unknown	1	3
Total	**31**	**98**

Table VII.4 displays the adjudications for each of the above thirty-one (31) charges. As can be seen from this table, ten of the thirty-one charges were not adjudicated as of 12/31/86, the cut-off date for the one year follow-up. One of the charges was dismissed, five were continued to another court date, four releasees were fined, three received probation, one received a suspended sentence, one was committed to a house of correction for less than 30 days and six were committed to a house of correction for more than 30 days.

Table VII.4

Adjudication of Charges Received by Residents Released for One Year

Adjudication	Number	Percent
Unadjudicated (Outstanding)	10	32
Dismissed	1	3
Continued	5	16
Fined	4	13
Probation	3	10
Suspended Sentence	1	3
Committed to House of Correction		
less than 30 days	1	3
30 days or more	6	19
Total	**31**	**99**

Of the 99 individual program completers followed for one year, 93 were not returned to a county house of correction, jail, or a state or federal prison for 30 days or more within one year of follow-up. The remaining 6 individuals were reincarcerated for 30 days or more during this period. Thus, the recidivism rate for the Longwood program was six percent.

The 6% recidivism rate for the Longwood Treatment is well below both the

overall recidivism rate in 1984 of 25% and the 1984 rate of 19% for other minimum/pre-release security level facilities (Lorant, 1986). However, the relatively small sample of 99 Longwood program completers precludes drawing firm conclusions concerning the recidivism rate for Longwood in comparison to other DOC institutions. It also remains to be determined as to whether this low recidivism rate remains stable or changes as long-term recidivism follow-up studies of the Longwood population are conducted.

C. Post-Release Drinking Behavior, Alcohol Counseling, and Employment Status

This section examines the impact of the Longwood program on post-release adjustment as indicated by self-reported drinking behavior, participation in alcohol counseling, and employment status. The information presented here was obtained from the results of telephone-based contacts and personal interviews conducted by the Longwood aftercare coordinator with program completers. The purpose of the aftercare component at Longwood is to maintain communication with released program completers in order to determine the extent to which they are complying with the terms of their aftercare contract by remaining alcohol abstinent and their general adjustment after being released from incarceration.

The following information was obtained from the records of the aftercare coordinator at Longwood who provided statistics relating to contact made between the aftercare coordinator and the ninety-nine program completers released from April 1985 through December 1985. Of the ninety-nine persons released during that period, 66% (65) were contacted by the aftercare coordinator by telephone within six months of release.

Before presenting these results, some caveats are in order. A large body of research has indicated that self-reports of drinking behavior are notoriously

unreliable with alcoholics and problem drinkers typically underreporting consumption levels both before and after treatment (Holden, 1987). However, aside from breathalyzer and blood alcohol test results which are only valid for very short time frames after drinking (since absolute alcohol (ethanol) generally oxidizes out of the bloodstream at the rate of one ounce per hour), there are currently no biological tests and few alternative means available with which to verify self-reported abstinence (except for the use of subject collaterals such as spouses), and thus, post-treatment measures of drinking behavior have typically relied on the self-reports of treated individuals.

Second, for those program completers placed on parole or probation, a self-report of drinking would constitute both a violation of their aftercare contract (which calls for abstinence) and, more seriously, a technical violation of their parole or probation. Therefore, there is a very strong incentive to report abstinence, even when drinking, so as not to be in violation of the aftercare contract or parole or probation. The self-reported percentage of those drinking at the follow-up points presented below should thus be treated as an extremely conservative estimate of the actual extent of drinking occurring among the released population. The fact that the follow-up interviews were conducted by the aftercare coordinator, a DOC employee, with the authority to report drinking by program completers to that person's parole or probation officer raises questions about the validity of self-reports of abstinence through aftercare follow-ups.

Finally, the aftercare coordinator asked program completers in the follow-up interviews if they were "sober". Instead, the appropriate follow-up question should have focused on if they were "abstinent". The dictionary definition of sober indicates that someone is temperate or sparing in the use of alcohol or not drunk. As such, use of the term "sober" in follow-up leaves open the possibility that respondents could truthfully report being sober (i.e., not drunk) but yet be drinking.

By contrast, abstinence, the goal of treatment and requirement of the aftercare contract, is defined as the act of voluntarily doing without alcoholic liquors. Had the aftercare questions been phrased in terms of abstinence, instead of sobriety, the number of program completers reporting to be abstinent may have been lower than the number reporting sobriety.

Of the ninety-nine Longwood releasees eligible for a one year follow-up, 86 were contacted in the year following their release. Sixty-five were contacted between one and six months of release, and thirty were contacted between six and twelve months of release. Nineteen persons contacted within the first six months of release were contacted for a second time between six and twelve months after release.

Personal interviews were conducted by the aftercare coordinator with twenty-nine (29%) of the ninety-nine graduates eligible for a one year follow-up. The purpose of the personal interviews was to attempt to provide some validation of the releasee responses to the telephone interviews. To do this, the aftercare coordinator examined such things as the respondent's ability to answer questions coherently, his or her personal hygiene, appearance, and living environment, whether they had a supportive spouse or housemate, and whether or not they were defensive when asked a question. Although still subjective, these observations provided some sense of how releasees were adjusting.

All graduates contacted by telephone and/or through a personal interview were asked: 1) if they have been drinking; 2) if they have been employed since incarceration; and, 3) if they have been attending AA and/or participating in other alcohol counseling. The results for each of these interview questions are presented below.

1. Post-Release Drinking

Of the 65 contacted from one to six months after release, 45 (69%) reported being sober, while 20 (31%) reported drinking since release and three of these individuals reported only a "brief relapse." Twenty-four (80%) of the 30 releasees contacted between six and twelve months after release claimed to be sober while 6 (20%) reported drinking since release.

Of the twenty-nine (29%) Longwood releasees who had a personal interview with the aftercare coordinator within one year of release, all were initially interviewed by telephone and claimed to be sober. Upon interviewing each of the 29 personally, it was determined by the aftercare coordinator that, in fact, 24 (83%) of the 29 releasees did actually appear to be sober. Five (17%) of the 29, however, appeared to be possibly drinking according to the subjective judgement made by the aftercare coordinator upon interviewing them.

2. Treatment Participation

Of the 65 residents questioned by the aftercare coordinator within the first six months of release, 52 (80%) claimed to be participating in either AA or other alcoholism treatment programs, 11 (17%) of the graduates interviewed were not in treatment of any kind, and information was unavailable for 2 (3%) of the graduates. Thirty (83%) of the 36 releasees interviewed by telephone between six and twelve months after release claimed to be participating in either AA or other alcoholism treatment programs while 6 (17%) were not in treatment of any kind.

3. Employment Status

Of the 65 residents interviewed by telephone within six months of release, 44 (68%) were employed, 19 (29%) were unemployed, and unemployment information was not available for the remaining 2 (3%) releasees. Twenty-nine (81%) of the releasees interviewed by telephone between six and twelve months were employed and seven (19%) were unemployed.

D. Chapter Summary

This section examined the impact of the Longwood program on post-release adjustment as measured by: 1) the number of individuals who were arrested for OUI and non-OUI offenses at least once subsequent to release from Longwood; 2) the number of individuals who were returned to prison within one year of release from Longwood (i.e., recidivism); 3) the post-release self-reported drinking behavior of Longwood releasees; 4) post-release alcohol counseling participation; and, 5) post-release employment status.

Program completers released from Longwood between 4/10/85 and 6/30/86 were followed-up at three, nine, and twelve months after release. Because the release dates for the sample of 263 program completers varied, fewer program completers were available for follow-up at the nine month and twelve month follow-ups than were available for the six month follow-up. Specifically, 263 or the entire population released from 4/10/85 - 6/30/86 were included in the six month follow-up; 174 or 66% of the 263 program completers were released from 4/10/85 -3/31/86 and were able to be included in a nine month follow-up; and, 99 or 38% of the 263 program completers released from 4/10/85 - 12/31/85 were able to be included in a twelve month follow-up.

Eighty-six percent (226) of the 263 program completers were arrest-free for six months after release, 4% (11) had at least one subsequent arrest for OUI, and 10% (26) had at least one subsequent arrest for a non-OUI offense. Of the 174 program completers available for study at the 9 month follow-up, 71% (123) were arrest-free nine months after release, 13% (22) had at least one subsequent arrest for OUI, and 17% (29) had at least one subsequent arrest for a non-OUI offense. At the 12 month follow-up, 69% (68) of the 99 program completers were arrest-free for 12 months after release, 11% (11) had at least one subsequent arrest for OUI, and 20% (20) had at least one subsequent arrest for a non-OUI offense.

Of the total ninety-nine individual program completers followed for one year, ninety-three were not returned to a county house of correction, jail, state or federal prison for 30 days or more within one year of follow-up. The remaining six individuals were reincarcerated for 30 days or more during this period. Thus, the recidivism rate for the Longwood program was six percent. This is well below the overall recidivism rate in 1984 of 25% and the 1984 rate of 19% for other minimum/pre-release security level facilities.

Regarding post-release drinking, of the 65 contacted by phone by the aftercare coordinator from one to six months after release, 45 (69%) reported being sober, while 20 (31%) reported drinking since release and three of these individuals reported only a "brief relapse". Twenty-four (80%) of the 30 releasees contacted between six and twelve months after release claimed to be sober while 6 (20%) reported drinking since release. Of the twenty-nine (29%) of the Longwood releasees who had a personal interview with the aftercare coordinator within one year of release, all were initially interviewed by telephone and claimed to be sober. Upon interviewing each of the 29 personally, it was determined by the aftercare coordinator that, in fact, 24 (83%) of the 29 releasees did actually appear to be sober. Five (17%) of the 29, however, appeared to be possibly drinking according to

the subjective judgement made by the after-care coordinator upon interviewing them.

Regarding post-release alcohol treatment 52 (80%) of the 65 releasees contacted by telephone claimed to be participating in either AA or other alcoholism treatment programs, 11 (17%) of the graduates interviewed were not in treatment of any kind, and information was unavailable for 2 (3%) of the graduates. Thirty (83%) of the 36 releasees interviewed by telephone between six and twelve months after release claimed to be participating in either AA or other alcoholism treatment programs, while 6 (17%) were not in treatment of any kind.

Forty-four (68%) of 65 residents interviewed by telephone within six months of release were employed, 19 (29%) were unemployed, and unemployment information was not available for the remaining 2 (3%) releasees. Twenty-nine (81%) of the releasees interviewed by telephone between six and twelve months were employed and seven (19%) were unemployed.

VIII. PROGRAM COST ANALYSIS

This section examines the costs of operating the Longwood Treatment Center. Included is a breakdown of program costs for each of the programmatic subsections and their totals within the fiscal year 1986 budget. This section also addresses the issue of whether the program is able to achieve its goals and objectives at a reasonable cost in comparison to other correctional institutional and alcohol treatment facilities.

The Longwood Treatment Center, with amended contract negotiations, was allocated $2,255,443 for FY 1986 which ran from July 1, 1985 through June 30, 1986. This money in turn was distributed among Longwood's fourteen subsidiary accounts which are:

- DOC Payroll and Personnel
- Valle Associates Contract
- Rental
- Food
- Office and Administrative
- Clothing and Supplies
- Farm and Ground Supplies
- Travel Expenses
- Advertising and Printing
- Equipment
- Maintenance
- Resident Wages
- Contract Services
- Housekeeping

DOC Payroll and Personnel

The DOC payroll and personnel subsidiary account was allotted $872,325 in FY 86 account for approximately 39% of the total FY 86 allotment, which was the most heavily funded account in Longwood's budget. The DOC payroll account supported DOC Administration, Security, Treatment, and Support staff at Longwood.

Valle Associates Contract

The second most heavily funded account at Longwood was the Valle Associates Contract, whose total allocation of $651,268 came from several contracts Valle had with the DOC to provide alcohol treatment at Longwood. The Valle contract accounted for 29% of the total Longwood Budget in FY 86. The combined Valle contract allotments were used to pay for administrative and direct care salaries, management and general supplies, staff training and bookkeeping.

Rental

The rental subsidiary account was allocated $478,391 which represented 21% of the total Longwood budget and was the third most heavily funded account. This account includes funds allotted for renting the building, automobile, and office equipment. However, the largest portion of this account, $429,000, went to the rental of the Longwood building per year, which includes the cost of utilities.

Food

Longwood was alloted $70,000 for the food subsidiary account which represents 3% of the total FY 86 budget.

Office and Administrative

Longwood was allocated $43,459 for the office and administrative subsidiary accounts which covers the costs for telephones, postage, and office supplies. This represents 2% of the total FY 86 budget.

Clothing/Supplies/Equipment et. al.

The combined allocations for clothing and supplies, farm and ground supplies, travel expenses, advertising and printing, and equipment was $28,000, or approximately 1% of Longwood's total FY 86 budget.

Maintenance

Longwood received $34,000 to cover funds for supplies to maintain and repair both the building and automobile and this represents 2% of the total FY 86 budget.

Resident Wages

Longwood was allotted $33,000 or 1% of the total budget for funds for residents' wages and stipends for residents working outside on work crews.

Employee training, security supplies and educational supplies were also covered by this account.

Contract Services

The subsidiary account for contract services was allotted $25,000 in FY 86 which represented 1% of the total Longwood budget. This covered contracted services for a protestant chaplain, medical consultant, and accreditor from the American Correctional Association.

Housekeeping

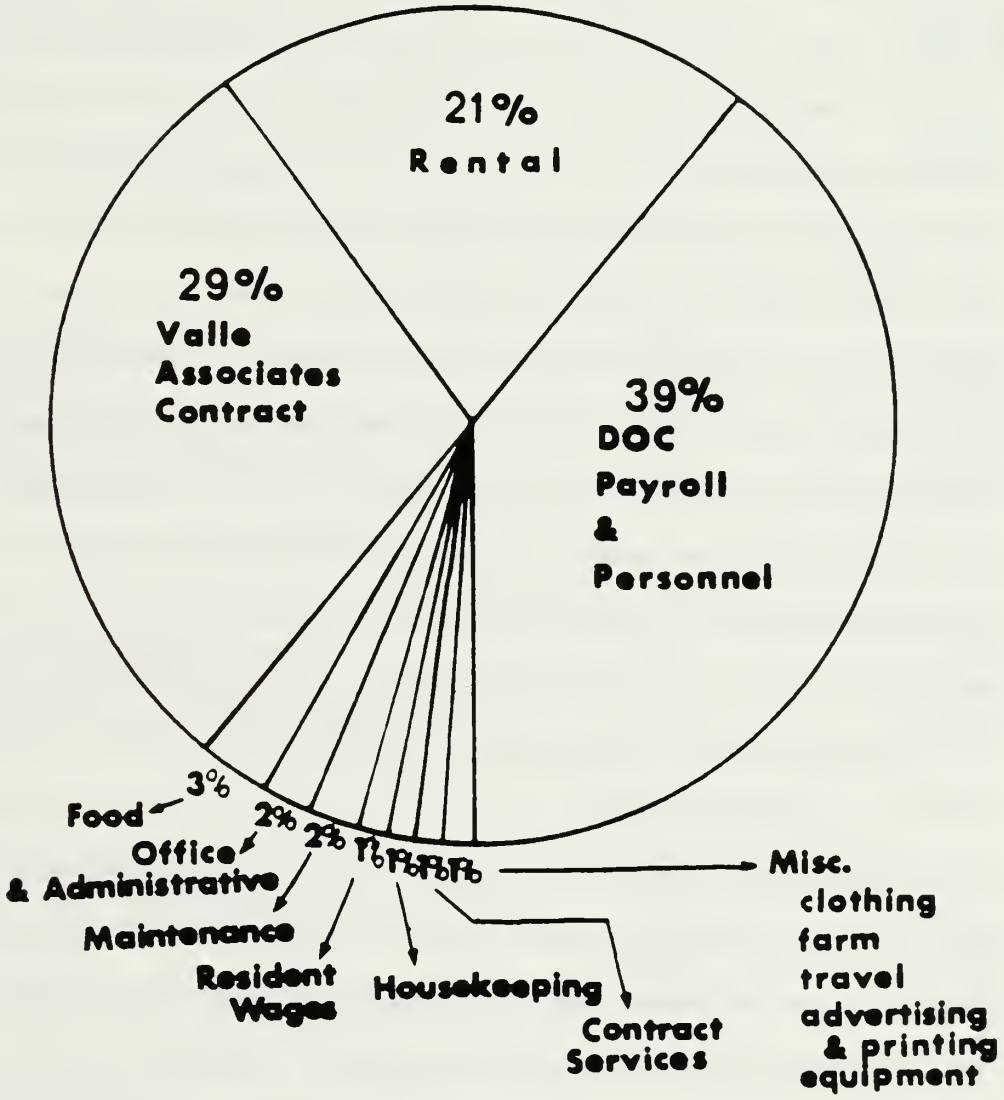
Longwood received $20,000 or 1% of their FY 86 budget to cover funds for cleaning, kitchen and laundry supplies, resident linens, blankets, and mattresses.

The cost figures for each subsidiary account are summarized in the chart below. As indicated, the largest portion of the Longwood budget totalling 89%, is consumed by three accounts: DOC Payroll and Personnel (39%); Valle Associates Contract (29%); and, Rental (21%).

In order to place these cost figures in context, and address the issue of whether Longwood meets its goals and objectives at reasonable cost, comparison of the average costs of housing an inmate at Longwood to other DOC facilities and the average costs of alcohol treatment at Longwood compared to other treatment programs were made.

Fig. VIII.I

LONGWOOD COSTS FY86



Average Inmate Cost

Housing inmates at Longwood is expensive and is illustrated by the fact that the average cost per day of housing an inmate at Longwood was $67.00 or $24,413 per year, higher than the total average inmate cost of $57.00 per day or $20,684 per year across all DOC institutions. Moreover, the average cost of housing an inmate at Longwood is higher than all the other minimum/pre-release facilities (MCI-Warwick, MCI-Shirley, and MCI-Lancaster) except for MCI-Plymouth, where the average cost is $69.00 per day or $25,360 per year (see Table VIII.1). Longwood is also more costly in terms of housing inmates than each of the six medium security institutions (MCI-Concord, MCI-Framingham, MCI-Norfolk, North Central Correctional Center, Southeastern Correctional Center, MCI-Bridgewater), each of the three minimum security institutions (Bay State Correctional Center, Medfield Prison Project, and Northeastern Correctional Center), and each of the four pre-release centers (Park Drive PRC, Norfolk PRC, South Middlesex PRC, and Boston State PRC). Only the two maximum security facilities (MCI-Cedar Junction and Lemuel Shattuck Hospital) and one minimum/pre-release facility (MCI-Plymouth), are more costly than Longwood.

In sum, the average cost of housing an inmate at Longwood is high relative to most other DOC facilities as well as from a traditional corrections perspective. Judging whether the inmate costs at Longwood are "reasonable", however, is more difficult and involves a more arbitrary assessment. For example, research cited by the Bureau of Justice Statistics (1983) has found a wide range among states, from $5,000 to $23,000, in the average annual operating cost per prisoner with $11,160 per year or $30.49 per day being the 1983 average. Since nearly one third of the total Longwood budget is consumed by the Valle Associates treatment contract, it is worth examining how the cost of the alcohol rehabilitative services provided by Valle Associates compares with other alcohol treatment programs.

Table VIII.1

Average Inmate Cost Per Day and Per Year in DOC Institutions: FY 1987

Institution/Security Level	Average Inmate Cost Per Day	Average Inmate Cost Per Year
Maximum		
MCI-Cedar Junction	$ 70	$25,648
Lemuel Shattuck Hospital	204	74,293
Medium		
MCI-Concord	59	21,493
MCI-Framingham	66	24,002
MCI-Norfolk	49	17,829
North Central Correctional Center	55	19,946
Southeastern Correctional Center	56	20,407
MCI-Bridgewater	55	20,034
Minimum		
Bay State Correctional Center	45	16,561
Medfield Prison Project	58	21,013
Northeastern Correctional Center	45	16,463
Minimum/Pre-Release		
MCI-Plymouth	69	25,360
Longwood Treatment Center	67	24,418
MCI-Shirley	64	23,480
MCI-Warwick	52	18,807
MCI-Lancaster	50	18,327
Pre-Release Center		
Park Drive PRC	60	21,791
Norfolk PRC	42	15,511
South Middlesex PRC	40	14,520
Boston State PRC	42	15,170
Total Average Cost	**$ 57**	**$20,684**

Cost of Alcohol Rehabilitation

This section examines the cost of alcohol rehabilitation at Longwood as compared to other alcohol treatment programs. Because there are a variety of alcohol treatment modalities which are conducted in different treatment settings over varying lengths of time, it is not possible to specify a standard cost for alcoholism treatment. Therefore, the average cost figures used here are for illustrative purposes only and do not reflect costs for equivalent types and settings of treatment as that provided at Longwood.

If one examines only the cost of alcohol treatment as measured by the costs of the Valle Associates contract, treatment costs could be considered very low from a residential treatment perspective. For example, dividing the total allocation for the Valle contract in FY 86 ($651,268) by the number of residents at Longwood (125) by the number of months in a year, yields a monthly treatment cost of $434 per inmate or $5,210 per year. On the surface, this compares very favorably with for-profit or proprietary residential treatment programs such as Spofford Hall in New Hampshire, where the cost for the 31 day alcohol treatment program is $8,200 or $265 per day. The costs of treatment per se at Longwood seem even less than more conservative estimates of typical treatment costs. For example, Fein (1984), citing a Health Care Financing Administration study of average hospital charges for diagnosis related groups, noted that the average charge per case in 1981 for the treatment of alcohol dependence paid out by Medicare for patients in acute care hospitals was $2,802.

However, the real cost of alcohol treatment at Longwood, like other residential facilities, should not be based solely on the amount of the cost of treatment per se but rather on the total average inmate costs of housing, securing, and treating an inmate. The real cost then is the previously cited average inmate

cost of $24,413 per year or $2,035 per month or $67 per day. We base the treatment cost on this total average inmate cost since, like other residential alcohol treatment programs, housing residents at Longwood also entails housing costs, staffing costs, etc. Moreover, the costs of alcohol treatment at Longwood are lower than other programs inpart because Longwood residents must be detoxed before entering the facility and the costs of detoxification are thus not borne by Valle or Longwood. When the costs of treatment are examined from this perspective, they are nearly identical to the average charges paid out by Medicare for the treatment of alcohol dependence in acute care hospitals, although nearly one-fourth the costs of proprietary, residential programs based on a 31 day length of stay model.

Were it not for the fact that Longwood is a prison and is therefore residential in nature, the cost of treating Longwood inmates could be even less if done on an outpatient basis. For example, there is no research evidence to indicate that inpatient treatment is more effective than outpatient treatment. (Solomon, 1981; National Institute of Alcohol Abuse and Alcoholism, 1983). However, outpatient treatment costs about one-third that of inpatient treatment.

In sum, the Longwood Treatment Center and Valle Associates specifically appear to be providing quality alcohol rehabilitation services at a reasonable cost. Although this lower cost is partially attributable to the fact that Longwood residents must be detoxified before entering Longwood, and thus the costs of detoxification are not assumed by the DOC or Valle, the costs of alcohol rehabilitation are still reasonable in comparison to the costs of other residential programs and hospital-based treatment.

Chapter Summary

This section examined the costs of operating the Longwood Treatment Center and addressed the issue of whether the program was able to achieve its goals and objectives at a reasonable cost in comparison to other correctional institutions and alcohol treatment facilities.

The Longwood Treatment Center was allocated $2,255,443 in fiscal year 1986. Costs were primarily attributed to the DOC Payroll and Personnel, Valle Associates Contract, and Rental accounts, which consumed, respectively, 39%, 29%, and 21% or together, 89% of the Longwood budget in FY86.

The per year average inmate cost at Longwood is $24,418 which is higher than the total average cost for all DOC institutions of $20,684 and which makes Longwood the fourth most costly of the 20 DOC institutions in terms of average inmate costs. This cost was found to be high from a traditional corrections perspective and in comparison to both other DOC institutions and national averages for state prisons.

The cost of alcohol rehabilitation was $2,035 per month or $67 per day. This compares very favorably with proprietary residential treatment programs where typical costs for a 31 day alcohol treatment program can run as high as $8,200 or $265 per day. The cost of alcohol rehabilitation at Longwood was also slightly less than the average hospital charge per case of $2,802 paid out by Medicare for patients in acute care hospitals in 1981.

IX. CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

The Longwood Treatment Center has now been in operation for two years. To date, approximately 500 sentenced drunk driving offenders have completed the Longwood program and have been paroled or discharged to the streets. The Longwood Treatment Center is one of a new crop of programs which seeks to combine corrections with treatment in order to prevent the reoccurrence of drunk driving among repeat offenders. In light of the relative newness of the concept underlying the Longwood Treatment Center, this evaluation focused on whether the program was implemented as planned, whether it reached the appropriate and specified target population, whether its services were effective in achieving intended goals and objectives, and whether these goals and objectives were achieved at a reasonable cost.

In general, the research findings are very positive in their reflection on program development, implementation, operation, and impact. Five general conclusions have arisen from the study findings. First, research revealed that the program was implemented as planned. While it is true that a series of internal and external pressures impacted the process of implementation and subsequently led to some programmatic and operational adjustments, the overall intended program structure and context was achieved.

Secondly, the research determined that the program served the originally intended target population. This was achieved from the existence of a variety of constraints that emerged in the complex process involved in the selection of clients for the program. Offenders in the program, for example, typically exhibit a prior

history of serious and multiple drunk driving offenses. Their histories of prior alcohol treatment revealed multiple contacts with detoxification and alcohol education programs, such as both privately and publically operated programs in mental health and public health agencies. The offenders were neither new to the courts nor new to the public and private alcohol treatment professionals. In short, prior histories of treatment and treatment failures were evident for the population as a whole.

Thirdly, the results of formal and informal evaluation techniques revealed a smoothly run professional program. Custodial staff, treatment staff, and management staff joined cooperatively in implementing and operating a unique program for the Department of Correction. The program involved a client population and a method of treatment heretofore not experienced by the staff. By the same token, program participants appeared cooperative, orderly, and in most cases sincere in their approach to participating in the alcohol treatment programs offered by the Center. This observation is made by comparing Longwood to other residential treatment programs and institutions administered by the Department of Correction. Relatively few residents were dropped from the program and returned to higher security institutions. Few disciplinary reports and incident reports were recorded. The escape rate was extremely low, less than 1% of the population at risk and better characterized as "walkaways" than as escapes. Additionally, the general institutional climate was consistently found to be a positive one.

Fourthly, the program is performing what appears to be quality cost-effective treatment. A combination of influences from the treatment methods employed by Alcoholics Anonymous and Reality Therapy particularly utilized in group settings best characterize this process. The use of an outside contracted treatment vendor, up to date educational materials, and the creative employment use of some recovering alcoholics as counseling staff are examples of efforts

undertaken to provide quality treatment.

Finally, preliminary outcome measures have revealed that relatively few individuals completing the Longwood Treatment Program and subsequently released to the streets on a parole or a discharge are rearrested and returned to prison for more than 30 days within one year of release. Our research has shown that 6% of the Longwood program completers were returned to prison within one year of program release. This compares to a department wide recidivism rate of 25% and a rate of 19% for other low security institutions similar to the Longwood program.

The generally positive findings documented through the research effort should not obscure the fact that the research also identified program areas in need of attention. While many program changes have been realized, and the Longwood program has been strengthened through the efforts of both the DOC and Valle staffs, there remain a number of areas that need attention. This is to be expected in any new program. The following section delineates salient issues identified through the research and presents recommendations for change.

B. Salient Issues and Recommendations

Salient issues refer to program areas in need of attention and modification. Six such areas were identified through the research: 1) the aftercare component; 2) the role of security staff; 3) the role of DOC and Valle counselors; 4) the lack of space and recreational facilities; 5) costs of the Longwood program; and, 6) post-Longwood outcomes. Each of these is discussed below along with recommendations for change in each area.

ISSUE 1: The Aftercare Component

Aftercare has been defined as "the process of providing continued contact which will support and increase the gains made to date in the treatment process" (Chafetz, 1974: 255) and the "variety of services offered after the period of intensive treatment is completed, as well as efforts to re-engage the client in treatment prior to formal termination". Aftercare typically consists of: 1) ongoing supportive activities, such as professional and self-help programs designed to maintain treatment gains, 2) prevention of costly rehospitalizations, and 3) improvement in social and occupational functioning (National Institute on Alcohol Abuse and Alcoholism, 1983).

The aftercare component was felt by both DOC and Valle staff at Longwood to be perhaps one of the most vital program features at Longwood and the primary way to ascertain program effectiveness. Ironically, this research has shown the aftercare component to be probably the weakest program feature at the facility. There are a number of reasons for this.

First, while the concept of aftercare has a relatively short history in the alcoholism treatment field, it is virtually non-existent in corrections, unless one construes parole or probation supervision as aftercare. Unlike alcoholism treatment facilities which today almost invariably encompass programs of aftercare or follow-up, once an inmate in a correctional facility is released, his or her commitment to the institution and its staff expire. Hence, the concept of aftercare in corrections inevitably has inherent difficulties foremost among which is the conflict between release and aftercare. This is best illustrated by the fact that for the majority of Longwood releasees who are placed on probation and or parole, a self-report of post-release drinking could result in a technical violation of both their aftercare contract and probation/parole.

At the same time, a growing body of research on the natural history and course of alcoholism after treatment has indicated that alcoholism is a multifaceted and highly variable disorder displaying no single course over time but instead involving frequent remissions, frequent relapses, and diverse behavior patterns (Polich et al., 1980). In short, Longwood graduates have a very strong incentive, namely, avoiding parole/probation revocation, to say they are abstaining when contacted by the aftercare coordinator even though they may desire and need additional treatment for a drinking problem which is, after all, the function of aftercare. This is also why, contrary to the opinion of DOC and Valle staff, aftercare is not the way to ascertain program effectiveness in a research sense.

The confusion among both DOC and Valle staff concerning the purposes of aftercare is reflected in the way aftercare is presented to program completers. At the start of both the telephone and personal interviews with released residents, the aftercare coordinator explains that the primary purpose of maintaining contact with releasees is a statistical one. Therefore, the residents are encouraged to be forthcoming and candid with their responses. They are not informed that the aftercare coordinator will notify the person's parole or probation officer of any serious violation of the terms of that person's release. Some residents are therefore misled into believing that the contact between the coordinator and the graduate is confidential. The purpose for the follow-up is not entirely clear to the releasees. This is because the custodial and treatment staff at Longwood are not in complete agreement as to the intent of aftercare.

A second problem with the aftercare component is that is has been assigned a low priority, reflected in the fact that when the facility opened, there was no aftercare coordinator or process for conducting aftercare. This situtation was partially remedied by the addition of a full-time aftercare coordinator in October 1985. However, the increasing number of released residents with whom to

maintain contact, coupled with the assignment of additional responsibilities to the aftercare coordinator, such as managing a caseload, has placed impractical expectations on this person.

Third, another weakness in aftercare concerns the period just prior to a program participant's release. The pre-release meetings between the prospective releasee and his or her DOC counselor and Valle counselor are brief and hurried. There is no formal counseling session in which the prospective releasee and his or her Valle counselor can discuss the resident's post-Longwood intentions regarding continuance of treatment, membership in AA, or anticipated difficulties in reintegration. Several respondents mentioned the need for a more thorough and structured pre-aftercare.

In response to these salient issues regarding the aftercare component, we offer the following recommendations.

RECOMMENDATION: Make the Aftercare Component A Priority.

For aftercare at Longwood to be an effective program component, it must be assigned a higher priority. However, before it can be assigned a higher priority, the specific purposes and goals of aftercare must be promulgated and agreed upon. This first involves stating what aftercare is and what it is not.

As a concept unique to the alcohol and drug treatment fields, aftercare represents a post-treatment extension of a person's individual recovery plan. Aftercare is not a mechanism for determining program effectiveness in a research sense. It should not be used to serve purely correctional or punitive functions by monitoring compliance with parole or probation. In a treatment model in which total, life-long abstinence is held out as an appropriate treatment goal for a disease called alcoholism and in which recovery is therefore seen as a life-long

proposition, both treatment providers and researchers would agree that one "slip" or relapse episode is not necessarily a program failure warranting the revocation of parole or probation.

The concept of aftercare adopted by Longwood should be partly informed by the lessons of research on the effectiveness of treatment for alcoholism which has consistently shown that, first, the course of alcoholism following treatment is highly variable and characterized by diverse behavior patterns, and frequent periods of both relapse and remission. Second, non-treatment, social stability factors have been consistently associated with successful treatment outcome and may be as, if not more important, than the amount and type of treatment received in predicting post-treatment outcomes. Specifically, steady employment, a stable marriage, higher education and income levels, and fewer arrests, have been found to be the most powerful predictors of treatment success (Solomon, 1981). Third, research has shown that socially unstable alcoholics of lower socioecomic status may need "extra treatment" supports such as job training, vocational training, and education if treatment gains are to be realized and maintained. In short, recovery from alcoholism and "drying out" as a result of treatment is only the first hurdle after which alcoholics may need the additional support available through aftercare.

As such, it is self-defeating to the goal of recovery to have the Longwood aftercare coordinator report incidents of post-release drinking by program completers to their parole or probation officers. This runs contrary to both the concepts of life-long recovery and is antithetical to the functions of aftercare. Moreover, such actions can only contribute to an unfavorable prognosis for those in recovery. In sum, aftercare should not be used as a mechanism to monitor compliance with parole or probation.

RECOMMENDATION: Develop a Pre-aftercare Program Component as Part of Phase III of the Treatment Plan.

In addition, Valle staff could be more active in actual follow-up. At least one member of the Valle staff could work with the DOC aftercare coordinator to conduct both telephone and personal interviews with released residents. In this way, treatment will complement information gathering, and releasees will understand that there is a representative from the alcoholism treatment staff working with them on their post-release adjustment. Maintaining contact with the correctional system (through a DOC aftercare coordinator) will thus be deemphasized but not eliminated, perhaps attracting more releasees to maintain communication if they are confident that aftercare is an extension of their individual recovery plans.

It should be explained to residents that the goals of aftercare are essentially the goals they have been working on throughout the program. One mechanism for accomplishing this is a more well-defined pre-aftercare program which could be incorporated into Phase III of the treatment plan and which could prepare residents for release. Such a pre-aftercare plan could involve one-on-one and/or small group counseling sessions designed to both allow residents to verbalize any apprehensions about rejoining society as abstinent individuals, as well as to ensure that they are aware of their responsibility to maintain contact with Longwood per the terms of the contract signed before they were admitted into the program. Both Valle and DOC treatment staff should operate this pre-aftercare component.

ISSUE 2: The Role of Security Staff at Longwood

A second area where criticism was raised concerned the role of security staff at Longwood. The Longwood security staff is comprised of 15 correction officers,

+ sergeants, and one lieutenant for a total of 20 security staff. Considering the nature of the facility, this large a security staff may be unnecessary. However, the presence of such a large security staff, coupled with frequent counts, partly accounts for the fact that the escape rate at Longwood was extremely low, less than 1% of the population at risk and better characterized as "walkaways" than as escapes.

Still, when asked by researchers to describe a typical resident at Longwood, nearly the entire staff likened him to "the guy next door". The Administration claimed that the typical resident was more like a patient than an inmate, non-confrontational and easy to manage. The DOC counselors claimed that he was abusive only in terms of his drinking, and the COs themselves asserted that he was non-violent, non-assaultive, friendly, and easy to manage. Futher, many residents complained that the security staff forget where they are, and treat the residents like children, or "like inmates at Walpole". The residents claimed that there are too many "petty" rules, the rules are inconsistent, and there are too many counts.

In fact, it is the opinion of the research team, that many of these complaints are justified. There are 36 counts conducted by security staff per day, 7 of which are major counts. During the seven major counts, all residents return to their rooms. During other counts, lectures, group therapy sessions, and other activities are interrupted. Thus, either the counseling activities are scheduled according to the time limits placed upon them by the major counts, or activities are interrupted by COs. Researchers frequently observed both lectures and highly personal and confidential group therapy sessions interrupted for resident counts.

RECOMMENDATION: Reorganization of Security Staff

Although the facility is a minimum security/pre-release, and the contribution of security personnel should not be underestimated, it is suggested that the security staff be reorganized to the extent permitted by civil service and other regulations. Specifically, we are suggesting a merger of the security staff with the DOC counselors, thus enabling security personnel a more direct role in case management and other administrative duties, while adding to the DOC counseling staff, freeing the DOC counselors from the primary responsibility for resident paperwork, and enabling them more involvement with residents and with Valle counselors in the delivery of counseling services. Further discussion of this proposed policy change follows.

ISSUE 3: The Roles of DOC and Valle Counselors

Another of the major problem areas cited by virtually all of the staff and residents interviewed concerned the role of DOC and Valle counselors at Longwood. Specifically, two issues were raised in reference to the counselors' role at the facility. The first concerned the lack of adequate one-on-one counseling, and the second concerned the role that DOC counselors play at Longwood.

a. **Inadequate Amount of One-on-One Counseling**

From the perspective of the residents interviewed, weekly one-on-one counseling is needed. From the perspective of the Valle staff, each counselor's caseload is too large and there is not enough time to administer adequate one-on-one counseling. From the perspective of the DOC counselors, the caseloads are too

shuffled and there is not enough time to meet with each resident on a regular basis.

Further, both counseling staff and residents question whether or not one-on-one counseling was meant to be incorporated into treatment at Longwood. Indeed, it is unclear if one-on-one counseling was intended as a program component. As was stated in the initial treatment plan submitted to the Boston Zoning Board by the Executive Office of Human Services, "individual treatment plans will be developed for each offender and may include... individual and/or group counseling...". Although Longwood engages all residents in group therapy, there are no regularly scheduled one-on-one counseling sessions between counselors and residents. Staff people at Longwood question the extent to which individual treatment plans tailored to the particular needs of each resident can be developed and complied with without meeting clients individually on a regularly scheduled basis.

b. Job Responsibilities of DOC Counselors

The second issue raised in reference to counselors concerned the responsibilities of the DOC counselors. It is unclear, many staff commented, whether the DOC counselors are strictly case managers, or serve a therapeutic function as well at Longwood.

From the perspective of the DOC Director of Treatment at Longwood, the DOC counselors are more than case managers, and do indeed aid in the treatment of the residents by meeting with them to discuss such things as legal issues. However, the DOC counselors themselves continually expressed uncertainty about the nature of their own positions. They commented that before the facility attained full capacity, they were much more involved in actual therapy, meeting with their caseloads regularly and meeting with each resident's respective Valle

counselor in weekly case conferences.

As the population at the facility increased, the responsibilities for processing residents' paperwork was assigned a higher priority than was meeting with the residents on a regular basis. In fact, when the research team completed the period of observation at Longwood in October 1986, the DOC counselors were meeting with their caseloads in brief sessions once per week. As of this writing, it has been learned that the DOC counselors are no longer able to meet even that frequently, and presently see their caseloads now once every two weeks.

RECOMMENDATION: Additional Staff Needed for One-on-One Counseling

In a review of the literature on alcohol treatment effectiveness, Solomon, (1981:1) has stated: "An opinion widespread throughout the alcoholism field is that treatment effectiveness will be maximized by tailoring therapeutic approach to fit the type of client served." In this same review, however, it was noted that there have been few attempts to assess the relative effectiveness of group versus individual therapy and that, if anything, treatment which combines both approaches holds the most promise. But here too, evidence supporting a combined approach is somewhat weak.

Despite the lack of research evidence to support individual over group therapy in the treatment of alcoholism, the availability of additional individual counseling is desirable for three reasons. First, the Longwood residents themselves expressed a desire for it. Second, Longwood staff also stated they would like to have conducted individual counseling. Third, it would strengthen a comprehensive treatment approach which research on alcohol treatment effectiveness has shown to be most promising.

In order to conduct one-on-one counseling sessions with each program

participant, more counseling staff, both DOC and Valle, need to be assigned to this task. Rather than adding staff per se, however, it is suggested that there be a reassignment of some security staff to assume some of the correctional counselor's functions.

It is suggested that weekly one-on-one sessions accompany group therapy. These sessions could be run cooperatively by both the resident's DOC and Valle counselor, and the two counselors should then resume case conferences. In this way, the DOC counselors would have more of a treatment role at Longwood, the Valle counselors would be able to meet with their individual caseloads more frequently, and the residents' individual needs would be addressed more effectively. By merging the security and DOC counseling staff into one unit responsible for both security and counseling, security could be maintained, counselors could play a more direct role in an individual's therapy, paperwork could be processed in a more timely fashion without impinging on direct care to residents, and resident's needs for individual attention would be met.

The Longwood Administration should devise a plan by which the two staffs could merge, then proceed to divide responsibilities among the larger "correctional counseling" staff. For example, tasks could be divided as follows:

- COs with interest and/or experience in administrative details could process the paperwork for furloughs, PRAs, work-release etc;
- COs and/or present counselors without a caseload could assume recreational/community and restitution/work-release responsibilities exclusively;
- a number of COs (with training) and present DOC counselors could divide the total number of residents into caseloads of not more than 15 residents each and assist in development of individual treatment plans, meeting with their caseloads regularly in one-on-one sessions and meeting with

their residents' respective Valle counselors in weekly case conferences; and,

- the remaining COs/DOC counselors could play a more direct role in pre-aftercare, aftercare, and networking with outside support groups.

The entire correctional counseling staff would be responsible for the security of the institution. Thus, three of the predominant areas of contention at Longwood could be addressed in one organizational restructuring. Security staff would assume less of a police function, DOC counseling staff would be more involved in direct care, and the aftercare component (including pre-aftercare) would be assigned a higher priority.

ISSUE 4: Lack of Space/Recreational Facilities

A criticism that was shared by all of the staff and residents at Longwood concerns the lack of recreational space at the treatment center. Aside from a small weight room and basketball court in the staff parking lot, there is virtually no room for residents to exercise or play ball, thus causing tension among residents. While cognizant of the fact that the residents are imprisoned at Longwood for a criminal violation, it is important to keep in mind that they are also alcoholics in the early stages of recovery, and that in and of itself may cause much tension. Many of the Valle staff interviewed emphasized the lack of and need for recreational activities at Longwood, suggesting that these particular residents especially need to locate alternative sources for which to relieve stress. In the past, staff maintained, they turned to the bottle or to their cars. Providing them with more healthy outlets would aid in their recovery.

RECOMMENDATION: Implement a Recreational Program

Although it is implausible to suggest adding more space for recreation, it is possible to implement a recreational program. It is recommended that a number of DOC correctional counselors spearhead the implementation of a mandatory recreational component, working either with the city of Boston or the local YMCA to ensure that supervised residents have a regular time and place in which to recreate.

ISSUE 5: Costs of the Longwood program

The costs of housing and treating inmates at the Longwood Treatment Center is high from a traditional corrections perspective and in comparison to other DOC institutions and national averages for state prisons. At a per year average inmate cost of $24,418, Longwood is the fourth most costly of the 20 DOC institutions. Only the two DOC maximum facilities (MCI-Cedar Junction and Lemuel Shattuck Hospital) and the minimum/pre-release facility (MCI-Plymouth) surpass Longwood in average inmate costs per year. The high costs of Longwood are primarily attributable to the DOC Payroll and Personnel, Valle Associates Contract, and Rental accounts which consume, respectively, 39%, 29%, and 21% or together, 89% of the FY86 Longwood budget.

RECOMMENDATION: Explore cost-saving measures

The DOC should explore a number of cost-saving measures which could have the effect of reducing average per inmate costs at the Longwood Treatment Center. Foremost among these measures is a reexamination of the current rental

arrangement and location of the Longwood Treatment Center. As mentioned earlier, the DOC leased the Longwood property and building for five years at a cost of $429,000 per year in order to examine the extent of incarceration resulting from the new law over a five year interval before investing money in other buildings. This lease expires in August 1989.

Now that the viability of the Longwood Program has been established and all beds have been filled, it is time to re-examine the current rental arrangement. Specifically, it is recommended that the DOC either issue a new RFP to house the Longwood Treatment Center in a less costly rental district or explore the outright purchase of a building. Because most Longwood residents do not come from the greater Boston area and yet the facility is located in Boston, the most expensive rental area in the state, there is no reason to continue to rent in the current location. Therefore, the facility should be re-located to a less costly district.

A final cost-saving measure could be a re-examination of the need to contract out for alcoholism treatment services. As noted earlier, when the original RFP for alcohol treatment specialists was issued in November 1984, the Commissioner of Correction expressed confidence that the DOC was capable of staffing the facility with its own alcohol treatment counselors. Now that the facility has been operational for two years, it is time to re-examine the need for contracted alcohol treatment services. In light of the prior recommendation to shift some of the correctional counselor functions to correctional officers and merging the two staffs, it is further recommended that DOC explore the feasibility of assigning DOC counselors the responsibility of providing alcohol treatment counseling to Longwood inmates.

ISSUE 6: Post-Program Outcomes and Recidivism

Although it was not the purpose of the present study to systematically examine post-Longwood outcomes in terms of re-arrest, drinking behavior, and recidivism, some preliminary results for an initial cohort of Longwood releasees were presented. While the preliminary results are useful for illustrative purposes, they are of less use in a evaluative sense.

RECOMMENDATION: The DOC Research Divison Should Conduct a Post-Program Outcome Evaluation of the Longwood Treatment Center

The present study has clearly established the feasibility of and need for an outcome evaluation of the Longwood Treatment Center. Now that the viability of the program concept has been established, it is time to systematically measure post-program outcomes and measure these outcomes against some comparison groups. The types of outcomes to be examined included post-release drinking behavior, re-arrest (OUI and non-OUI), recidivism, alcohol counseling participation, and social adjustment (i.e., employment status). Appropriate comparison groups might be county-OUI inmates and/or repeat OUI offenders incarcerated in similar facilities such as the Western Massachusetts Correctional Alcohol Center (where the DOC Research Division is undertaking a post-program outcome study). Such a study could be conducted over a longer post-release follow-up period and would have the advantage of providing more valid and reliable statistics than those obtained through the aftercare process.

C. Chapter Summary

Now over two years old, the Longwood Treatment Center represents a new approach in the corrections field in which the concepts of corrections and alcohol treatment are merged in an effort to prevent the reoccurrence of drunk driving among repeat offenders. The purpose of this evaluation was to examine whether the Longwood program was implemented as planned, whether it reached the appropriate and specified target population, whether its services were effective in achieving intended goals and objectives, and whether these goals and objectives were achieved at reasonable cost.

In general, the research findings are very positive in their reflection on program development, implementation, operation, and impact. Five major conclusions have arisen from these findings. First, the program was implemented as planned. Second, the program served the originally intended target population. Third, Longwood was found to be a smoothly run professional program. Fourth, although the average inmate costs at Longwood are high, the program is providing quality cost-effective alcohol treatment. Finally, relatively few individuals completing the Longwood program and released on a parole or discharge are rearrested and returned to prison within one year of release.

Despite the generally positive findings, there are number of program areas in need of attention. First, the aftercare component needs to be assigned a higher priority. A pre-aftercare program component needs to be incorporated into the treatment plan. Second, there should be a reorganization of security staff to assume some of the correction counselor functions. Third, both DOC and Valle counseling staff should conduct more one-on-one counseling. Fourth, there is a need to implement a recreational program. Fifth, cost-saving measures should be explored. Sixth, the DOC Research Division should conduct a post-program outcome evaluation of the Longwood Treatment Center.

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